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	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Delaware	2270 Warrensburg Road Delaware, OH 43015

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, review of facility audits, and review of facility policy, the facility failed to ensure resident room temperatures were maintained at a comfortable level above at least 71 degrees Fahrenheit (F). This affected five Residents (#18, #60, #71, #74, and #102). Additionally, the facility failed to maintain a clean environment of common area furniture in the memory care unit affecting 19 Residents (#11, #15, #28, #29, #32, #40, #45, #47, #48, #50, #56, #60, #66, #69, #71, #72, #79, #82, and #83) who resided in memory care. Facility census was 90. Findings include: 1. a. Review of temperatures for the past several months revealed temperatures had been taken several times each week. The most recent temperature included from 01/03/26 to 01/10/26 which showed six days at 71.0 degrees Fahrenheit (F) one day at 72.0 degrees and one day at 70 degrees. There were no further records of temperature checks from 01/11/26 through 01/21/26. Interview on 01/21/26 at 12:00 P.M. with Maintenance Director (MD) revealed the facility should be conducting room temperature checks daily and he provided the most recent records of the temperatures. He confirmed he had no record of temperature checks being done from 01/11/26 to 01/21/26 and confirmed he was aware of room heating issues and had electricians onsite 01/20/26 to review issues for about five resident rooms. MD #220 reported the facility had no other documentation related to the monitoring of temperatures. Interview on 01/27/26 at 9:40 A.M. with Maintenance Staff #124 revealed Maintenance Director #220 was with corporate staff. He stated the electricians were involved and had to rewire the whole panel as it was previously done wrong. He reported the corporate Maintenance was coming in this date (01/27/26) and they were planning to turn up the base heat from the boiler system but confirmed it had not warmed the rooms sufficiently and stated he was not sure when the electricians would be back out to fix the electrical issues. Interview on 01/27/26 at 10:30 A.M. with Regional Staff #210 and Maintenance Staff (from a sister building) #226 reported he checked out the boiler, and one of the two circulator pumps were turned off. He reported he turned on the pump to the boiler and confirmed the PTAC units also emitted heat as the boiler system was not enough to maintain temperatures. They also reported the electricians onsite 01/20/26 were for a quote and they did not yet have a date of when the work would be completed for the electrical issues. Review of the facility audit dated 01/27/26 completed by Maintenance staff #124 revealed 15 of 56 rooms had temperatures lower than 71 degrees F, indicating they were outside the required temperature range, with one documented as per resident preference. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Loss of Heating of Cooling dated 03/16/22, revealed it was policy for the facility to take immediate action to maintain facility with the 71 to 81 degree requirement. Maintenance should conduct routine inspections related to the heating and cooling system and staff should notify the Administrator and Maintenance Director of any issues or concerns that arise. b. Review of the medical record for Resident #71 revealed an admission date of 04/26/24. Diagnoses included traumatic brain injury, malnutrition, post traumatic stress disorder, dysphagia, encephalopathy, dementia with agitation, depression with psychotic features and panic disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 12 indicating intact cognition and was independent with mobility and toileting. Observation and interview on 01/20/26 at 3:30 P.M. with Resident #71 revealed her Packaged Terminal Air Conditioner (PTAC) was off with a pair of pants shoved in the vent. The vent had a red error light stating to replace the filter. The residents room felt cold and the resident confirmed she placed her pants in the vent to attempt to get the warm air to go up as she thought it was all blowing down and under the bed. Resident #71's bathroom felt very cold. Observation and interview on 01/20/26 from 4:50 P.M. to 5:00 P.M. with Maintenance Director (MD) #220 confirmed the error light on Resident #71's PTAC machine stated to replace the filter. MD #220 opened the machine and found a thick layer of dusk and stated they would need to fix that. He took the air temperature of the room and found it ranged from 66 to 69.7 degrees F and also took temperature of the bathroom which read 59.6 degrees F. He stated the resident bathrooms had no temperature control ability. He revealed he was aware of a handful of rooms that had issues and needed electrical work to fix their temperature devices but reported Resident #71 was not on the list. c. Review of the medical record for Resident #60 revealed an admission date of 09/13/24. Diagnoses included pelvic fractures, dementia, emphysema, pulmonary hypertension, weakness, and dysphagia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 00 indicating resident was rarely if ever understood and required maximum assistance for mobility and transfers. Observation on 01/20/26 at 3:40 P.M. with Resident #60 revealed his PTAC (personal room temperature wall unit) was off and the resident's room felt cold. Observation and interview on 01/20/26 from 4:50 P.M. to 5:00 P.M. with Maintenance Director (MD) #220 confirmed Resident #60's PTAC machine was turned off. MD #220 turned on the machine, and a buzzing could be heard but no air was felt from the vent. He stated it would take several minutes to get it to kick on. He took the air temperature of the room of 67.4 degrees F and also took temperature of the bathroom which read 54.4 degrees F. He stated the resident bathrooms had no temperature control ability. He revealed he was aware of a handful of rooms that had issues and needed electrical work to fix their temperature devices but reported Resident #60 was not on the list. Observation on 01/22/26 at 3:00 P.M. with Resident #60 revealed his PTAC had been replaced and was on and set to 76 degrees. The residents room felt to be at a comfortable temperature. d. Review of the medical record for Resident #102 revealed an admission date of 01/19/26. Diagnoses included cerebral infarct, type two diabetes, and bipolar disorder. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 14 indicating intact cognition. The resident was also assessed to require partial and moderate assistance for ambulation and hygiene. Observation on 01/27/26 at 9:30 A.M. revealed Resident #102's room felt cool in temperature and the PTAC machine was off. Surveyor attempted to turn the PTAC machine on and the on/ff button did not work. Interview and observation on 01/27/26 at 9:40 A.M. with Maintenance Staff #124 revealed Maintenance Director #220 was with corporate staff. He took temperature readings of Resident #102's room and found it read 66.5 to 67.0 degrees F and confirmed the PTAC unit was not working. He confirmed Resident #102's room was not previously on the list of resident rooms with known issues. Interview on 01/27/26 at 9:55 A.M. with Resident #102 revealed the temperature was cold since she moved in about a week ago. e. Review of Resident #18's medical record revealed an admission date of 07/11/25 and the following medical diagnoses: cerebral infarction due to embolism of right middle cerebral artery, unspecified atrial fibrillation, morbid obesity, orthostatic hypotension, venous insufficiency, obstructive and reflux uropathy, adult failure to thrive, dysphagia, major depressive disorder, and obstructive sleep apnea. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Interview on 01/20/26 at 11:20 A.M. with Resident #18 stated that the heater in their room was not working. The resident stated it was very cold in their room and that the facility stated that they were working on fixing the heating issues. Observation on 01/20/26 at 4:43 P.M. revealed two air temperatures of 68.0 and 67.7 degrees in Resident #18's room. Further observation revealed an air temperature of 63.0 degrees F in the bathroom of Resident #18. Interview on 01/20/26 at 4:44 P.M. with Maintenance Director #220 confirmed the air temperatures were too low and did not meet the minimum temperature requirements. f. Review of Resident #74's medical record revealed an admission date of 7/10/25 and medical diagnosis of hemiplegia and hemiparesis follow cerebral infarction (CVA) affecting right dominant side, dysphagia following cerebral infarction, flaccid hemiplegia affecting right nondominant side, acquired absence of right left above knee, cerebral infarction, hyperlipidemia, chronic pulmonary embolism, dysuria, anxiety disorder, alcohol abuse opioid abuse, and cocaine abuse. Review of Resident #74 Care Plan last revised 1/20/26 revealed impaired musculoskeletal status related to amputation with interventions to encourage the resident to ask for assistance when needed. Further review revealed an activity of daily living (ADL) deficit related to amputation, CVA, flaccid hemiplegia to right side, and anxiety disorder. Interventions include two-person assistance with transfers. Interview on 01/20/26 at 1:29 P.M. with Resident #74 revealed she was cold, unable to reach the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Packaged Terminal Air Conditioner (PTAC) to adjust the room temperature, and the PTAC unit had not worked for multiple weeks. Observation and temperature checks on 01/20/26 at 4:32 P.M. of Resident #74's room with Maintenance Director #220 revealed a room temperature of 69.6 degrees F. Interview on 01/20/26 at 4:33 P.M. with Maintenance Director #220 confirmed the facility was working on replacing the PTAC unit as of 01/20/26. 2. Observation on 01/20/26 at 3:30 P.M. of the memory care unit revealed a red leather chair with a brownish caked on splatter stain on the back rest of the chair and the seat and sides of the chair. Observation on 01/21/26 from 9:30 A.M. to 4:30 P.M. revealed various residents were seated in the chair. Observation and interview on 01/22/26 at 3:00 P.M. with Certified Nursing Aide (CNA) #110 confirmed the red leather chair was donated from a previous resident and confirmed it had a brownish splatter. She stated it was likely food and stated she had seen housekeeping wiping it off before and stated it should be maintained in a clean manner. CNA #110 confirmed the two cup holders had black crumbs like coffee grounds and trash and wrappers in the cup holders and in the cracks around the seat cushion including three straws in their wrappers. Review of facility policy titled Cleaning Schedules dated 02/01/22, revealed it was policy for the facility to identify the functional areas in the facility that require cleaning and maintain regularly scheduled environmental service tasks. Review of facility policy titled Routine Cleaning and Disinfection dated 02/01/22, revealed it was policy for the facility to provide routine cleaning in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Consistent surface cleaning and disinfection shall be conducted with a detailed focus on high touch areas including resident chairs. This deficiency represents noncompliance investigated under Master Complaint Number 2724818 and Complaint Number 2713632.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, interview, review of the facility transfer and discharge log, and review of facility policy, the facility failed to ensure a safe discharge when on 11/29/25, Resident #99 was sent to the hospital and on 12/01/25 the facility was aware the resident would be receiving an involuntary discharge, but his representative was not made aware until 12/16/25 when the facility dropped off Resident #99 at the residents representatives home. This affected one (#99) of three residents reviewed for discharge. The facility census was 90.Findings Include: Review of medical record for Resident #99 revealed an admission date of 07/11/25 with diagnoses including dementia, diabetes mellitus type two, and encephalopathy. The record indicated the residents wife was his responsible party. Review of Resident #99's nurses notes revealed on 11/29/25 the resident received a pink slip due to physical aggression with staff. The resident was transported via facility bus to a psychiatric hospital. Report was given to the hospital. Review of the facility's transfer and discharge log revealed Resident #99 was transferred to the hospital on [DATE] with an expected return.Review of the physician progress note dated 12/01/25 revealed that Resident #99 spontaneously pushed two residents and physically struck a staff member. It noted that it would be appropriate to issue an immediate discharge to prevent harm to residents or staff. The facility was unable to provide documentation demonstrating the resident's representative was notified of an impending involuntary discharge, provided written notice, or afforded appeal rights prior to the discharge occurring on 12/16/25.Review of the hospital documentation dated 11/29/25 through 12/16/25 revealed Resident #99 was discharged from the hospital on [DATE] with plans to return to his admitting facility via hospital transport. Review of a facility-issued discharge notice revealed an immediate involuntary discharge date d 12/16/25. The notice stated the reason for discharge was related to the safety of the individuals in the home was endangered and the health of the individuals in the home would otherwise be endangered. It also noted the specific reason for discharge was that Resident #99 intentionally physically assaulted two residents and a staff member, resulting in physical bodily harm, and Resident #99 had the physical ability to continue to carry out such harm. Review of the facility Ombudsman notification documentation dated 12/16/25 revealed that the Ombudsman was notified of Resident #99's discharge. Review of the medical record for Resident #99 revealed it did not demonstrate discharge planning, interdisciplinary evaluation, or assessment of the safety or appropriateness of the discharge location prior to transport. Interview on 01/22/26 at 12:43 PM with the Regional Director of Operations (RDO) #210 confirmed the facility knew of the residents planned immediate discharge on [DATE] and they picked Resident #99 up from the psychiatric hospital in their transport bus on 12/16/25 and transferred him to the resident's representatives home address. The representative did not answer the door but spoke to the resident and the previous Administrator through the doorbell camera. The Administrator then had Resident #99 transferred to a local hospital via the facility transport bus because the wife would not take him back and he could not return to the facility. The RDO stated Resident #99 (or his representative) were not provided the opportunity to appeal or have discharge implementation because it was an emergency discharge. Interview on 01/22/26 at 2:20 PM with Resident #99's representative revealed she was not notified prior to 12/16/25 that the facility would not accept the resident's return and was not provided the opportunity to appeal the discharge prior to its implementation. Resident #99's representative further confirmed she was not provided the opportunity to prepare for Resident #99's discharge. She further stated the frequent transfers from facility to facility continuously triggered his PTSD and did not allow him appropriate time to (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adjust to his new surroundings. She said she took care of her elderly mother and this was a big barrier to why he would not be suitable to be at home with her. Resident #99's representative stated the resident was at the local hospital for two days and around 12/18/25 he was transferred to a Veterans Affairs (VA) facility. She stated she felt more supported with the assistance from the VA.Review of the facility's policy titled Discharge Planning Process, dated 10/18/20, revised 10/30/23, revealed the facility is required to involve the resident and/or representative in discharge planning and provide education and communication prior to discharge. It also stated the facility will ensure the discharge destination meets the resident's health and safety needs and preferences.This deficiency represents noncompliance investigated under Complaint Number 2702415 and 2682740.

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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 interviews, record review, and review of facility policy, the facility failed to ensure Resident #76 had a care plan to address post-traumatic stress disorder triggers. This affected one resident (#76) of 24 residents reviewed in the sample. Census was 90. Findings include:Review of the medical record revealed that Resident #76 was admitted on [DATE] and had a documented diagnosis of Post-Traumatic Stress Disorder (PTSD). Review of Resident #76's Social Service Progress Review dated 10/02/25 (signed 10/03/25) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, and identified multiple behavioral symptoms, including physical and verbal behaviors directed toward others, rejection of care, and socially inappropriate behaviors. The Social Service Progress Review identified triggers including people messing with my stuff and documented calming strategies such as talking things out and engaging in preferred activities. The assessment further documented trauma history and completion of trauma-informed care screening. Review of Resident #76's care plan revealed no care plan interventions addressing PTSD-related triggers, staff approaches to avoid known triggers, trauma-informed strategies specific to identified triggers, or communication of triggers to direct care staff. On 01/27/26 at 7:45 A.M., an interview with Licensed Practical Nurse (LPN) #133 revealed that male staff were a known trigger for Resident #76 and that staff attempted to limit male caregivers when possible. LPN #133 stated staff attempted redirection and verbal engagement when the resident became upset. On 01/27/26 at 10:45 A.M., an interview with the Social Services Director (SSD #243) confirmed awareness that Resident #76 was frequently involved in incidents requiring redirection. When asked whether the resident's triggers were documented in the care plan, SSD #243 stated they should be and confirmed upon review that they were not, indicating the care plan would need to be updated. Review of the facility policy titled Comprehensive Care Plans (implemented 01/01/21, revised 06/30/22) required the facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet identified medical, nursing, mental, and psychosocial needs identified through the comprehensive assessment process. The policy further required care plans to be developed by the interdisciplinary team and reviewed and revised after comprehensive and quarterly MDS assessments.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to ensure residents with a history of trauma received trauma-informed care by identifying and addressing trauma-related triggers. This affected three residents (Resident #49, Resident #76, and Resident #99) out of twelve residents identified with post-traumatic stress disorder. The facility census was 90.Findings include: 1. Review of the medical record revealed Resident #76 was admitted on [DATE] with diagnoses including post-traumatic stress disorder (PTSD) and unspecified dementia, along with additional comorbid conditions. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score indicating cognitive impairment, requiring staff assistance with decision-making and care. Review of the Annual Social Service Progress Review (V10) dated 10/02/25 (signed 10/03/25) documented that trauma-informed care screening was completed, and Resident #76 met criteria for a trauma history. The assessment documented behavioral symptoms including verbal and physical behaviors directed toward others, rejection of care, socially inappropriate or disruptive behaviors, and episodes requiring redirection. Review of the same Social Service Progress Review identified triggers and calming strategies, including distress when people mess with my stuff, and calming interventions such as talking things out, engagement in preferred activities, and comfort foods. Interview on 01/27/26 at 7:45 A.M. with Licensed Practical Nurse (LPN) #133 revealed that male staff were a known trigger for Resident #76. LPN #133 stated staff attempt to limit male caregivers from providing direct care when possible and attempted redirection and verbal engagement when the resident becomes upset. Review of the comprehensive care plan revealed Resident #76's diagnosis of PTSD was documented; however, the care plan did not identify male caregivers as a trauma-related trigger and did not include trauma-informed, trigger-specific interventions or staff approaches related to this known trigger. Review of the facility policy titled Comprehensive Care Plans, implemented 01/01/21, revised 06/30/22, required the facility to develop and implement a comprehensive person-centered care plan that addresses identified medical, mental, and psychosocial needs based on assessment findings and to revise the care plan as resident needs change. 2. Review of medical record for Resident #99 revealed an admission date of 07/11/25 with diagnoses including dementia, diabetes mellitus type II, and encephalopathy. Review of admission documentation dated 07/11/25 from a Veterans Affairs facility identified PTSD as a diagnosis for Resident #99. Review of the resident's care plan initiated 07/11/25, revised 11/19/25, revealed impaired mood and psychiatric status related to PTSD. Review of the facility's Trauma-Informed Care assessment revealed PTSD was marked as No, and social services assessments did not identify PTSD or document trauma history. The medical record did not demonstrate that trauma-related triggers were identified or that individualized trauma-informed interventions were implemented. Interview on 01/27/26 at 9:21 AM with Social Services Director (SSD) #157 revealed that when a (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident has a diagnosis of PTSD, it is expected that the resident be assessed for trauma history and PTSD-related triggers, and that identified triggers be documented and communicated to the interdisciplinary team. Review of the facility's policy titled Trauma-Informed Care, dated 10/18/20, revised 10/24/22, revealed the facility is responsible for screening residents for a history of trauma upon admission, identifying trauma-related triggers, and implementing individualized interventions to mitigate re-traumatization. The policy further revealed trauma history and identified triggers are to be documented and communicated to the interdisciplinary team. 3. Review of the medical record for Resident #49 revealed an admission date of 12/27/18 with diagnoses of [NAME] Sequard syndrome, quadriplegia, reduced mobility, insomnia, PTSD, generalized anxiety, major depressive disorder and chronic pain syndrome. Review of the care plan dated 02/22/24 revealed Resident #49 was at risk for impaired mood and psychiatric status related to depression, PTSD, and anxiety. Interventions included assisting the resident to cope by discussing possible solutions to conflict, observing for signs of mood changes or distress, observing the resident for sleep pattern changes, providing the resident with quality listening time and encouraging expression of feelings. Review of the social service progress reviews dated 01/13/25, 04/16/25 and 07/18/25 revealed under trauma informed care, Resident #49 had a diagnosis of PTSD, resident reports symptoms were being managed effectively, and the facility has not identified any known triggers. Review of the mental health visit note dated 09/05/25 revealed follow up for chronic PTSD and adjustment disorder with depressed mood. Resident #49 reported feeling more depressed since the last visit related to the death of a friend and continued frustration about service connection and reported having poor sleep and nightmares. Recommended trial of mirtazapine (antidepressant) 15 milligrams (mg) every night for sleep and mood. Review of physician order dated 09/08/25 revealed mirtazapine oral tablet 15 mg give one tablet by mouth at night due to diagnosis of insomnia. Review of social service progress review dated 10/17/25 revealed under trauma informed care, resident has diagnosis of PTSD. Resident #49 reported symptoms were being managed effectively, and the facility had not identified any known triggers. Interview on 01/27/26 at 8:35 A.M. with Resident #49 confirmed diagnosis of PTSD due to military service history. The resident reported it was being poorly managed at this time and reported persistent night terrors and insomnia at night, currently receiving three to four hours of consistent sleep where previously reporting seven to eight hours at night. Resident #49 reported interest in talking with social services pertaining to management of PTSD and identification of any possible triggers or factors affecting daily life. Interview on 01/27/26 at 9:20 A.M. with SSD #157 confirmed current diagnosis of PTSD for Resident #49. SSD #157 confirmed triggers identified were documented in social service progress review and confirmed the resident does not have any documented in the review or in his current care plan. Interview on 01/27/2026 at 9:36 A.M. with LPN #133 was unaware of PTSD triggers for Resident #49. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/27/26 at 10:36 A.M. with the Director of Nursing (DON) confirmed Resident #49's diagnoses of PTSD should have triggers identified in care plan and should be monitored often. This deficiency represents noncompliance investigated under Complaint Number 2702415.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews and policy review, the facility failed to ensure safe and sanitary storage of food items. The facility also failed to ensure proper hand hygiene during food service. This had the potential to affect all facility residents except two residents (#24 and #80) who the facility identified to be NPO (had no oral intake). The facility census was 90. Findings include:1. Observations and interviews on 01/20/26 from 9:15 A.M. to 9:25 A.M. with Kitchen Manager #205, District Manager #206, and Regional Dietician #207 revealed two loose bags of cauliflower, a loose bag of mixed vegetables, two loose bags of bread sticks, one loose bag of fries, one loose package of cinnamon rolls and one loose package of breakfast pastries were left undated. A bag of corn was opened and undated and a bag of fries were undated. Several of the bags had chunks of ice stuck to them in the freezer and no thermometer was found in the freezer. In the refrigerator, there was an unlabeled green lunch bag that had two bottles of soda and ice packs. A second plastic grocery bag was found to contain an unlabeled bottle of water and a Tupperware container with food in it was found in the bag. District Manager #206 reported she did not know who or what the two bags were for and confirmed employees should not be storing personal food in the kitchen refrigerator mixed with resident food. A container of applesauce was found on the bottom of the refrigerator, and District Manager #206 and Kitchen Manager #205 confirmed it should have been in dry storage and placed in an open box of applesauce containers. In dry storage, a large container of sugar was found to be uncovered/unsealed. The undated items were confirmed to not have any dates or documentation on the packaging of when it was delivered to the facility and removed from the freezer and placed on the counter. Interviews on 01/20/26 from 12:00 P.M. to 2:00 P.M. with District Manager #206 and Regional Dietician #207 revealed the unopened bags of food had a manufacture date on them and they were returned to the freezer. Review of the facility policy titled, Food Receiving and Storage, dated 07/01/25, revealed dry storage and items in the refrigerator and freezer shall be labeled and dated. Review of the facility policy titled, Quick Resource Tool (QRT) Food Storage, dated 09/01/21, revealed freezer temperatures shall be maintained at or below 0 (zero) degrees Fahrenheit (F) and an accurate thermometer shall be maintained in the freezer. All food shall be stored in wrapped or covered containers, labeled and dated.2. Observations and interviews on 01/21/26 from 11:40 A.M. to 11:53 A.M. revealed [NAME] #208 had gloved hands and tongs to take burgers off the foil lined cooking sheet and place on the steam table. With the same gloves, [NAME] #208 wrapped up the foil with grease and pulled out the trash can and placed foil in the trash can. With the same gloves, [NAME] #208 then grabbed all the meal tickets and started going threw them and pulling out tickets for residents that were in the dining room. [NAME] #208 then went in and out of the kitchen to the dining room two separate times with the meal tickets without performing any glove changes or hand hygiene. Then with the same gloves, [NAME] #208 started working on the tray line and made up three plates for the resident trays. After surveyor intervention, [NAME] #208 was instructed by Regional Manager #206 to perform hand hygiene, and she washed her hands and changed her gloves. Review of the facility policy titled, Quick Resource Tool (QRT) Hand Washing, dated 09/01/21, revealed staff shall wash their hands in designated handwashing sinks and gloves were not a substitute for handwashing. It was important to perform hand washing before working with food or utensils, before putting on gloves, after handling soiled equipment or utensils and when changing tasks.

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	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Delaware	2270 Warrensburg Road Delaware, OH 43015

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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 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 record review, observation, staff interview and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented in accordance with national infection control standards for a resident with risk factors indicating the need for such precautions. Specifically, the facility failed to post required signage or provide visual cues to alert staff to use EBP during high-contact care activities for Resident #6, despite the resident having open, draining skin lesions and other conditions placing the resident at increased risk for transmission of infectious organisms. This affected one resident (#6) of one resident reviewed for EBP. Additionally, the facility failed to ensure appropriate assistance for incontinence care was provided for Resident #15, resulting in the lack of infection control when the resident was seen walking around with feces on his shoes. This affected one resident (Resident #15) out of three residents reviewed for bladder and bowel services. The facility census was 90.Findings include:1. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that include type two diabetes mellitus with diabetic neuropathy, chronic venous insufficiency, post-traumatic stress disorder, unspecified dementia with behavioral disturbance, chronic respiratory failure with hypoxia, and history of malignant melanoma of the skin, among other conditions. The resident's diagnoses of diabetes with neuropathy, chronic venous insufficiency, cognitive impairment, and active non-pressure skin lesions placed the resident at increased risk for skin breakdown and transmission of infectious organisms during high-contact care activities.Review of the Minimum Data Set (MDS) 3.0 assessment with an Assessment Reference Date of 12/01/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of twelve, indicating cognitive impairment. The MDS documented the resident required extensive assistance or dependence for multiple activities of daily living, including toileting hygiene and transfers, requiring frequent hands-on care by staff.Review of physician orders dated 01/20/26 revealed an active order for EBP during high-contact care activities for Resident #6. Despite the presence of physician orders and documented clinical risk factors, observations confirmed no signage or visual alerts were in place to support staff awareness or compliance with EBP.On 01/22/26 at 9:30 A.M., 11:15 A.M., and 3:05 P.M., this surveyor observed the entrance to Resident #6's room to determine whether EBP were implemented. During all three observations, no signage or visual indicators were posted on the resident's door or immediate room entrance to identify the requirement for EBP.At the time of each observation, staff were observed entering and exiting the resident's room without visual cues or posted instructions identifying the need to don gown and gloves during high-contact care activities.On 01/22/26 at 3:10 P.M., this surveyor interviewed the Director of Nursing (DON) regarding infection control precautions for Resident #6. When asked whether Resident #6 should be on EBP based on the resident's diagnoses and skin conditions, the DON stated, Yes, he should be. When asked whether signage should be posted to indicate the need for EBP, the DON stated that signage should have been placed on the front of the resident's room and acknowledged that it was not present at the time of observation.Review of the facility's Infection Prevention and Control / Enhanced Barrier Precautions policy, revised 03/26/24, revealed the facility policy requires that residents who meet criteria for EBP have clear visual indicators or signage posted at the resident's room entrance to alert staff to the required use of gown and gloves during high-contact care activities. The policy further requires staff to follow these precautions consistently to reduce the risk of transmission of infectious organisms.2. Medical Record review for Resident #15 revealed an admission date of 01/11/23 and medical diagnosis of dementia, cerebral infarction (CVA), obstructive and reflux uropathy, major depressive disorder, abnormal gait and mobility, muscle (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness, lack of coordination, need for assistance with personal care, and cognitive communication deficit.Review of Resident #15 Minimum Data Set (MDS) assessment, last updated 01/08/25, revealed the resident had severely impaired cognitive decision making and he required clean-up assistance with toileting hygiene, and was frequent incontinent of bowel and bladder. Further review revealed the resident had episodes of bladder and bowel incontinence related to cognitive impairment and dementia.Review of Resident #15's Care Plan last updated 01/14/26 revealed an activity of daily living (ADL) self-care deficit related to cognitive impairment, CVA, and dementia with interventions to allow the resident to independently toilet and to offer to help as needed.Observation on 01/21/26 at 10:08 A.M revealed Resident #15 in the 400-hall common area with brown splatter marks on their shoes.Interview on 01/21/26 at 10:09 A.M. with Licensed Practical Nurse (LPN) #136 confirmed the brown splatter marks on Resident #136's shoe was stool and it was cleaned up by LPN #136. LPN #136 confirmed the expectation for all residents was to remain clean and staff were to assist residents with incontinence care as needed.Review of facility policy, Incontinence last revised 10/26/23 revealed, based on the residents' comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services.This deficiency represents noncompliance investigated under Master Complaint Number 2724818.