

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|--|
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>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 (continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>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.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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. (continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>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.</p> <p>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 dust 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Interview on 01/20/26 at 1:29 P.M. with Resident #74 revealed she was cold, unable to reach the Packaged Terminal Air Conditioner (PTAC) to adjust the room temperature, and the PTAC unit had not worked for multiple weeks.</p> <p>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.</p> <p>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. (continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>Observation on 01/21/26 from 9:30 A.M. to 4:30 P.M. revealed various residents were seated in the chair.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number 2724818 and Complaint Number 2713632.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of activities calendars, and policy review, the facility failed to ensure a variety of activities of interest were planned throughout the day including weekends as well as age-appropriate activities. This affected one resident (#5) of one reviewed for activities and had the potential to affect 19 residents in memory care (#11, #15, #28, #29, #32, #40, #45, #47, #48, #50, #56, #60, #66, #69, #71, #72, #79, #82, and #83). Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 01/02/26 and discharged on 01/21/26. Diagnoses included acute respiratory failure with hypoxia, influenza, heart failure, end stage renal disease, diabetes, osteomyelitis, left foot drop, partial amputation of the right foot, weakness and altered mental status.Review of Resident #5's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition and the resident required partial/moderate assistance of staff members for bed mobility and substantial maximum assistance from staff for transfers and ambulation.Review of the plan of care dated 01/05/26 revealed the resident was at risk for alteration in psychosocial well-being with interventions to provide activities of choice and encourage participation.Review of activity assessment dated [DATE] revealed Resident #5 would require staff assistance for ambulation.Review of Resident #5's progress notes revealed no mention of activities, staff offering at assist to get to activities or resident refusals.Review of the activity calendar for non memory care residents dated January 2026 revealed the daily chronical was scheduled daily Monday through Saturday and exercise was scheduled daily Monday through Saturday. They also included resident choice activities 11 days of the month and lunch was included as an activity. No facility organized activities were available/scheduled on Sunday's and only mentioned that residents could watch church on television. The activity calendar revealed no activities after 10:30 A.M. on Saturdays and on 01/22/26, activities typically ended by 2:00 P.M. on Tuesdays and Fridays, and 3:00 P.M. Mondays and Thursdays with the only evening activity being Poker Wednesdays. The activity calendar on 01/20/26 did not include bingo games.Observation on 01/20/26 at 10:30 A.M. revealed a few residents were in the activity room playing bingo. Resident #5 was not included.Interview on 01/20/26 at 10:36 A.M. with Resident #5 revealed he would enjoy playing games or bingo, but needed assistance getting out of bed and getting to the activity. He revealed he had an activity calendar and confirmed it did not include bingo this date (01/20/26). Resident #5 revealed staff did not come around prior to activities and encourage residents to attend and offer assistance.Consistent observation on 01/22/26 from 8:40 A.M. to 10:00 A.M. revealed the daily chronical was scheduled to be given at 9:00 A.M. and was not passed out until about 9:30 A.M. and was not reviewed, just handed out or placed on residents' bedside tables. Additionally, staff did not check on residents and provide assistance to the exercise activity unless they were already out in the hallway. Observations of the non-memory care area revealed residents that were in bed were not assisted or included in the activity.Interview on 01/22/26 at 2:35 P.M. with Activity Director #102 and confirmed facility staff should be encouraging attendance and assisting residents to get to the activities. 2. Review of the memory care calendar dated January 2026 revealed lunch and dinner were included as daily activities and the daily chronical, our daily bread, word search (on the daily chronical), exercise, and coffee with snacks were offered daily from Mondays through Thursdays and alternated between tv time (television) and chatting with friends. Activities ended at 1:30 P.M. on Saturdays and only mentioned watching church on the television on Sunday's.Interview on 01/22/26 at 2:35 P.M. with Activity Director #102 revealed she had been the Activity Director for about three years. She revealed the facility recently hired an activity aide for memory care and prior to that, memory care residents were mainly in the common area watching television. She confirmed the calendar was repetitive and did not include many evening or weekend activities. She revealed she was working on the calendar to get more creative and acknowledged the calendar should encompass (continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>all activities that were going on so all residents had a chance to join in, and confirmed facility staff should be encouraging attendance and assisting residents to get to the activities. She revealed she was working on expanding the calendar to new games and craft activities. She also confirmed activities and toys should be age appropriate and confirmed a Surprise Learning Box (a toy that was observed as a foam box with an open lid and different flaps and pieces and pockets on the side) slated for three months old and up, and infant toys, were not appropriate for elder care residents with memory impairment. She reported the previous administrator got residents baby dolls and a toddler stroller and she stated she felt it was a fall risk as residents would need to bend down to push the stroller. She revealed she had asked about fidget aprons/blankets and was told it was out of budget to get those items. Interview and observation on 01/22/26 at 3:00 P.M. with Certified Nursing Aide (CNA) #110 confirmed the memory unit had a few baby toys and was not sure why they were purchased. She confirmed Resident #60 on the memory care unit had an infant toy in his room in the packaging. It was a fabric cube with an opening at the top and a second version was in the common area. CNA #110 reported the previous administrator, and activities, had purchased these toys for residents. Review of facility policy titled Activities dated 10/30/23, revealed it was policy for the facility to provide ongoing programming to support residents in their choices of activities and based on preferences. Individual and group activities shall meet the needs and interests of the residents. Residents shall be encouraged to participate and shall include indoor and outdoor activities, activities away from the facility, religious programs, exercise programs, community activities, social activities, in-room activities and educational programming. Special Considerations shall be made for developing meaningful activities for residents with dementia or special needs.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure the activities program is directed by a qualified professional.</p> <p>Based on staff interview, and review of personnel files, the facility failed to ensure an appropriate staff member was employed who was certified and had adequate experience to plan and execute activities in the facility. This had potential to affect all residents except the 19 residents residing in the memory care unit (#11, #15, #28, #29, #32, #40, #45, #47, #48, #50, #56, #60, #66, #69, #71, #72, #79, #82, and #83). Facility census was 90. Findings include: Review of the activity calendar dated December 2025, and January 2026 revealed they were repetitive and did not have a variety of activities. Review of the personnel file for Activity Director (AD) #102 revealed she was not a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered, if applicable, by the State in which practicing. It also noted she was not eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body, she did not have two years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program, she was not a qualified occupational therapist or occupational therapy assistant, and she had not completed a training course approved by the State. Interview on 01/22/26 at 2:35 P.M. with Activity Director (AD) #102 revealed she had been the Activity Director for about three years. She revealed the facility recently hired an activity aide for memory care on 10/07/25. She reported her and another activity aide worked with the non-memory care part of the building and confirmed the facility did not have a certified activity aide until 10/07/25. Interview on 01/22/26 at 4:20 P.M. with Regional Director of Operations #210 and Interim Administrator #300 confirmed the facility did not have a certified activity staff member until 10/07/25 when they hired Activity Aide #100. They reported they believed the facility did not need a certified activity aide, but that the activity director could be hired with two year's experience, in the past five years and they stated she met that requirement. Further review of Activity Director #102's personnel file revealed she had worked in activities at a previous facility from February 2022 to November 2022 for a total of nine months experience and did not report any other activity staff/jobs on her resume. Interview on 01/27/26 at 2:35 P.M. with Regional Nurse #225 confirmed the Activity Director's resume only indicated nine months experience working in an activity capacity. She confirmed no additional experience was related to activities.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review and policy review, the facility failed to ensure puree food was made to the proper consistency by following facility recipes. The facility also failed to maintain the nutritional value of the food item. This affected four Residents (#22, #30, #69 and #82) identified by the facility as receiving puree diets. The facility census was 90. Findings include: Observation and interview on 01/21/26 from 10:15 A.M. to 10:42 A.M. with [NAME] #208 and Regional Manager #207 revealed she was making five to six servings of the puree items. [NAME] #208 revealed they had about 34 ounces of ground beef and added about one-third cup of beef broth unmeasured and blended the mixture, and then the cook added two tablespoons unmeasured of thickener. [NAME] #208 stated she was looking for pudding consistency. The mixture had visible chunks and was tasted and found to have small distinct pieces. Regional Manager #206 confirmed it needed to be blended more and placed back in the mixer along with an unmeasured teaspoon of broth and two unmeasured teaspoons of thickener then another unmeasured tablespoon of thickener was added. Regional Manager #206 asked if facility staff was using a recipe, and the cook confirmed they only had the menu with serving sizes. Regional Manager #206 went to the computer and printed the recipe for the ground beef and provided it to the cook who did not review or use the recipe. Review of the facility recipe dated 2026 revealed the hamburger stroganoff shall be mixed with beef broth to get the desired consistency. It stated any liquid specified in the recipe was a suggested amount (if needed) and some recipes would require no liquid added to achieve the desired consistency. It also stated if the product needed thickening gradually add in an appropriate amount of liquid to achieve smooth, pudding or soft mashed potato consistency. If the product needs thickening gradually add food thickener to achieve a smooth pudding or mashed potato consistency. Observation and interview on 01/21/26 from 10:43 A.M. to 10:56 A.M revealed [NAME] #208 made puree broccoli. Kitchen Manager #205 placed an unmeasured four to five cups of broccoli in the Roboku mixer, and [NAME] #208 added one-half cup of unmeasured broth and one-third cup of unmeasured thickener to the mixer. [NAME] #208 placed the mix in a container and confirmed it was completed. No recipe or instructions were observed to be used during the puree process for the broccoli. Review of the facility recipe dated 2026 revealed the broccoli (two and one-half cups) shall be mixed with two tablespoons of margarine with instructions to place prepared vegetables and margarine in the mixer and blend until smooth. It stated any liquid specified in the recipe was a suggested amount (if needed) and some recipes would require no liquid added to achieve the desired consistency. It also stated if the product needed thickening gradually add in an appropriate amount of liquid to achieve smooth, pudding or soft mashed potato consistency. If the product needs thickening gradually add food thickener to achieve a smooth pudding or mashed potato consistency. Observation and interview on 01/21/26 from 10:57 A.M. to 11:05 A.M revealed [NAME] #208 made puree noodles. Kitchen Manager #205 placed an unmeasured about 20 ounces of cooked noodles in the Roboku mixer, and [NAME] #208 added one and one-half cups of unmeasured whole milk and about two tablespoons of unmeasured thickener to the mixer. [NAME] #208 placed the mix in a container and confirmed it was completed. No recipe or instructions were observed to be used during the puree process for the noodles. Review of the facility recipe dated 2026 revealed the noodles shall be mixed with broth and melted margarine gradually as needed and blended until smooth. It stated any liquid specified in the recipe was a suggested amount (if needed) and some recipes would require no liquid added to achieve the desired consistency. It also stated if the product needed thickening gradually add in an appropriate amount of liquid to achieve smooth, pudding or soft mashed potato consistency. If the product needs thickening gradually add food thickener to achieve a smooth pudding or mashed potato consistency. Interview on 01/21/26 at 12:50 P.M. with [NAME] Manager #206 and Regional Dietician #207 acknowledged the puree was not made to the correct consistency (continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | and recipes were not reviewed or used when making the puree textures. Review of the facility policy titled, Therapeutic Diet Orders, dated 07/01/25, revealed the facility shall provide food in the appropriate form to meet resident needs and the appropriate nutritive content as prescribed. | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|--|---|
| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure that resident dignity was maintained for Resident #80. This affected one resident (#80) of two residents reviewed for dignity. The facility census was 90. Findings Include: Review of Resident #80's medical record revealed an admission date of 07/09/25. Further review revealed the following medical diagnoses: aphasia, hemiplegia and hemiparesis, chronic respiratory failure, hyperlipidemia, nontraumatic intracranial hemorrhage, other seizures, communication deficits, dysphagia, unspecified mood disorder, muscle weakness, anxiety disorder, anemia, and encephalopathy. Review of Resident #80's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) was not conducted due to the resident never/rarely being understood. Observation on 01/20/26 at 10:41 A.M. revealed Resident #80 lying in bed wearing only an incontinence brief. The resident's bed was in full view of the hallway with multiple people observed walking by the doorway. No blankets or clothing items were observed on the bed or on the floor. Interview on 01/20/26 at 10:45 A.M. with Certified Nurse Aide (CNA) #156 confirmed Resident #80 was wearing only an incontinence brief in full view of the doorway. CNA #156 stated that the resident pulled his clothes off when he was dressed. The CNA left the room without providing a cover up for the resident or pulling the resident's privacy curtain. Interview on 01/22/26 at 2:48 P.M. with the Director of Nursing (DON) #119 stated that the expectation for the staff was to maintain privacy for every resident. DON #119 stated that if a resident had pulled their clothes off, the expectation for the staff would be to cover them with clothing and/or blankets or to pull their room curtain for privacy.</p> |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**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 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 (continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>Based on record review and staff interview, the facility failed to ensure the Preadmission and Resident Review (PASRR) was completed accurately. This affected one resident (#3) of two reviewed for PASRR. Facility census was 90. Findings include: Review of the medical record for Resident #3 revealed an admission date of 06/16/25. Diagnoses included displaced fracture, spinal stenosis, unspecified dementia, and bipolar disorder. Review of the physician order dated 06/16/25 to 06/17/25 revealed an order for Quetiapine Fumarate (psychotropic medication) Oral tablet 25 milligrams (mg) with instructions to give one tablet every six hours as needed for agitation. Review of the physician order from 06/16/25 to 09/19/25 revealed an order for Quetiapine Fumarate extended release (ER) 24 hour oral tablet 200 mg with instructions to give one tablet at bedtime for bipolar disorder. Review of the Preadmission and Resident Review (PASRR) dated 07/15/25 revealed the resident was not prescribed any antipsychotic medications within the six month period of time prior to the completion of the PASRR assessment. Interview on 01/27/26 at 9:17 A.M. with Social Services #157 confirmed the PASRR dated 07/15/25 did not document accurate medication psychotropic medications. She confirmed Resident #3 had orders for antipsychotics from 06/16/25 that were incorrectly eliminated on the assessment. She was not sure if putting accurate medication would have made a change in whether the resident qualified for level two services, but reported it should have been completed accurately. Review of facility policy titled PASARR (Pre-admission Screen and Resident Review dated 10/30/23, revealed facility shall coordinate assessments with preadmission screening and resident review. All residents are required to have a level one screen and when indicated a level two screening.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL). This affected one (Resident #72) of five residents reviewed for ADL assistance. The facility census was 90. Finding include: Medical record review for Resident #72 revealed an admission date of 05/09/22 and medical diagnosis of dementia, hypertension, osteoarthritis, dysphagia, feeding difficulties, need for assistance with personal care, urinary incontinence, muscle weakness, and difficulty walking. Review of Resident #72's Care Plan last updated 11/07/25 revealed an ADL self-care performance deficit related to dementia and functional limitations in range of motion with interventions to provide one person assistance with dressing. It also noted an impaired neurological status related to dementia with interventions to assist with normal daily tasks as needed. Review of Resident #72 Minimum Data Set (MDS) dated [DATE] revealed the resident was dependent on personal hygiene, dependent on lower body dressing, and was frequently incontinent of bowel and bladder. Observation on 01/20/26 at 11:35 A.M. revealed Resident #72 was observed on the 400 hall pacing the halls with her wheelchair by scooting her feet along the floor. The resident had one sock on her foot, and the other foot was barefoot. She had long toenails and was bumping into items and door frames and wandering into other resident rooms. Follow up observation on 01/20/26 at 3:24 P.M. revealed Resident #72 with a sock on one foot and the other foot was barefoot. Interview on 01/20/26 at 3:27 P.M. with Certified Nursing Assistant (CNA) #111 confirmed the resident only had one sock on and was known to remove clothing. The resident was then allowed to continue to wander the unit with one sock. Review of facility policy, Activities of Daily Living last revised 12/28/23 revealed the facility will ensure residents who are unable to care out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure appropriate care and services to treat a residents new non-pressure related wounds. This deficient practice affected one resident (#2) of one resident reviewed for non-pressure related wounds. The facility census was 90. Finding include: Medical record review for Resident #2 revealed an admission date of 10/17/25 and medical diagnosis of osteomyelitis, chronic obstructive pulmonary disease, type two diabetes, atherosclerotic heart disease, heart failure, anemia, need for assistance with personal care, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of Resident #2's Care Plan, last updated 11/10/25, revealed an impaired cardiovascular status related to congestive heart failure, heart failure, atherosclerotic heart disease, hypertension and anemia. Interventions included to observe for side effects and report to physician, nurse practitioner, or physician assistant. The care plan further revealed the resident had an impaired metabolic status related to diabetes and hyperlipidemia with interventions to report any adverse changes in skin integrity. Additionally, the care plan stated the resident was at risk for impaired skin integrity related to cancer diagnosis, confined to bed all or most of the time, confined to the chair all or most of the time, diabetes, hemiplegia, needs assistance with activities of daily living, obesity, right above the knee amputation, chronic kidney disease, congestive heart failure, osteomyelitis, type two diabetes, and atherosclerotic heart disease. Interventions included to float the left heel, assist resident with turning and repositioning as needed, complete skin inspections weekly and as needed. Review of Resident #2 Minimum Data Set (MDS) dated [DATE] revealed lower extremity impairment on both sides, dependence on staff for toileting hygiene and lower extremity care, and an active diagnosis of peripheral vascular disease. The assessment noted the resident had no venous or arterial ulcers and there were no problems with his feet. Further review of Resident #2's medical record revealed no documented evidence of any current wounds to the resident's foot. Observation and interview on 01/20/26 at 11:31 A.M. with Resident #2 revealed three open non-covered wounds to the residents left foot. Observation on 01/22/26 at 10:04 A.M. of Resident #2 revealed three open non-covered wounds to the residents left foot and numerous bloody marks on the foot of the residents' bed. Interview on 01/22/26 at 10:05 A.M. with Resident #2 confirmed the bloody marks on the foot of the bed were from the open wounds on their left foot and occurred when they pushed against the foot of the bed to reposition themselves. Interview and observation on 01/22/26 with the Director of Nursing (DON) confirmed the presence of three open non-covered wounds on Resident #2's left foot and dried blood on the foot of the bed. The DON further confirmed the facility was unaware of the wounds and would be contacting the Nurse Practitioner for orders and further assessment. Interview on 01/22/26 at 2:50 P.M. with Nurse Practitioner (NP) #804 confirmed the facility had not contacted them regarding the three wounds on Resident #2 left foot and all three wounds would be classified as arterial wounds. The NP stated the wounds would be treated with iodine and should be left open to air. Further interview with NP #804 confirmed the expectation was for the facility to assess residents and report any changes of condition. Review of facility policy, Wound Treatment Management last revised 10/26/23 revealed wound treatments will be provided in accordance with physician orders, including cleansing method, type of dressing, and frequency of dressing change. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and review of the restorative nursing program, the facility failed to ensure a restorative splinting program was implemented. This affected one (Resident #49) out of one resident reviewed for mobility and limited range of motion. The facility identified 10 residents as receiving range of motion programming. The facility census is 90. Findings include: Review of the medical record for Resident #49 revealed an admission date of 12/27/18 with diagnoses of [NAME] Sequard syndrome, quadriplegia, venous insufficiency, contracture of muscle and reduced mobility. Review of physician spine visit summary dated 01/21/25 revealed the Resident #49's contractures appeared stable at this time. Review of care plan dated 02/05/25 revealed Resident #49 would benefit from a restorative splinting program related to contractures and limitation in range of motion. Interventions included to provide splinting program, wear right and left-hand carrot finger orthosis, to be applied with evening care and removed with morning care. Review of Resident #49's tasks dated and marked as resolved on 03/12/25 revealed a maintenance restorative nursing splint and brace assistance. Resident #49 was to wear right and left-hand carrot finger orthosis, to be applied with evening care and removed with morning care as tolerated. Upon applying and removing check skin integrity. Review of occupational evaluation and plan of treatment dated 11/19/25 revealed Resident #49 had functional limitations due to contractures from the diagnosis of [NAME] Sequard syndrome. Occupational therapy was not currently managing impairment and nursing was managing the patient's contracture impairment. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 was cognitively intact, required no restorative nursing programs, had functional limitation in range of motion on both upper extremities and was dependent on staffing assistance for hygiene needs. Observation on 01/21/26 at 7:34 A.M. revealed Resident #49 did not have carrot splint (or its equivalent) in place. Observation on 01/27/26 at 7:42 A.M. revealed Resident #49 did not have carrot splint (or its equivalent) in place. Interview on 01/27/26 at 8:30 A.M. with Licensed Practical Nurse (LPN) #133 confirmed Resident #49 had bilateral hand contractures, they had not seen the resident wearing carrot orthosis or rolled cloths (or its equivalent) and was unsure if night shift applied the care planned interventions. LPN #133 confirmed there were no physician orders for the preventative measures. The LPN stated they were in place in the past and she was unsure if the resident was continually refusing therefore, they discontinued them. Interview on 01/27/26 at 8:35 A.M. with Resident #49 confirmed he was not currently receiving splinting programs on his bilateral hands. The resident was able to identify the carrot orthosis which was noted as soiled with a collection of dust on a food storage rack under some cans located by the bed. Resident #49 was agreeable to applying the preventative measures, however declined any decline in range of motion due to not participating in the restorative splinting program. Review of active physician orders on 01/27/26 at 10:03 A.M. revealed no splinting orders were in place for Resident #49's bilateral hands. Interview on 01/27/26 at 10:36 A.M. with the Director of Nursing (DON) confirmed Resident #49 did not have any active physicians orders for bilateral hand contractures. It was active on the care plan and she was unsure why the task was resolved on 03/12/25. The DON stated the physician would be notified and asked if they would like to resume the restorative splinting program. In addition, the DON confirmed if a resident was to receive a program, they should have documentation of when it was applied. Review of physicians orders dated 01/27/26 at 1:06 P.M. revealed Resident #49 had orders to wash and dry left hand, apply moisturizer then apply rolled washcloth. Additionally wash and dry right hand, apply moisturizer then apply carrot orthosis. Review of restorative nursing program dated 01/01/22 revealed the goals of restorative nursing programming include improving and or maintaining independence in activities of daily living and mobility. Residents who could benefit from a program include those requiring contracture prevention and or management.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on interview, record review, observation, and policy review, the facility failed to ensure catheters were maintained in a sanitary manner for Resident #7. This affected one resident (Resident #7) out of three residents reviewed for bladder and bowel services. The facility census was 90. Findings include:</p> <p>Review of the medical record for Resident #7 revealed an admission date of 11/06/25 with diagnoses including stage three pressure ulcer of the right buttock, altered mental status, gastroesophageal reflux disease, bladder neck obstruction, and weakness.</p> <p>Review of the care plan dated 12/19/25 revealed Resident #7 required a Foley catheter related to obstructive uropathy. Interventions included observing for signs and symptoms of infection, assisting with indwelling catheter care, changing catheter and drainage system as clinically indicated, monitoring for obstruction, infection or compromise of the closed system, and maintaining the drainage bag below bladder level.</p> <p>Review of physician order dated 12/20/25 revealed Resident #7 had orders for a Foley catheter to straight drain related to bladder neck obstruction.</p> <p>Review of significant change Minimum Data Set (MDS) 3.0 assessment completed 12/23/25 revealed Resident #7 was cognitively impaired, required an indwelling catheter and required partial or moderate assistance with toileting and bed mobility.</p> <p>Observation on 01/20/26 at 11:10 A.M. revealed Resident #7 was lying supine in bed with the bed in the lowest position. The resident's catheter tubing was observed without obstruction or kinks. The urinary drainage bag and drainage mechanism were in direct contact with the floor.</p> <p>Observation on 01/20/26 at 2:53 P.M. revealed Resident #7's catheter remained in the same position with the drainage mechanism in direct contact with the floor.</p> <p>Observation and interview on 01/20/26 at 3:33 P.M. with Licensed Practical Nurse (LPN) #133 confirmed Resident #7's urinary drainage bag was in direct contact with the floor. LPN #133 stated they were unsure how to correct the issue due to the bed being maintained at a low position.</p> <p>Interview on 01/27/26 at 10:36 A.M. with the Director of Nursing (DON) confirmed drainage bags should not be in contact with the floor and stated that if contact occurred the bag should be placed in a protective cover or basin.</p> <p>Review of catheter care procedure dated 12/28/23 revealed the facility is to provide catheter care to all residents with an indwelling catheter to reduce bladder and kidney infections.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to implement dietary orders for Resident #75. This affected one resident (Resident #75) out of five residents reviewed for nutrition services. The facility census was 90. Findings include:</p> <p>Review of Resident #75's medical record revealed an admission date of 06/28/25 and the following medical diagnoses: acute kidney failure, malignant neoplasm of prostate, unspecified protein calorie malnutrition, dementia, major depressive disorder, Bell's palsy, muscle weakness, dysphagia, urine retention, abdominal aortic aneurysm, weakness, and adult failure to thrive.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition.</p> <p>Review of the care plan with a review start date 01/08/26 for Resident #75 revealed the resident was at risk for altered nutritional status related to advanced age, edentulous status, history of significant weight changes, supplement use, mechanically altered diet, dementia and failure to thrive. Interventions included to periodically obtain resident's weight, evaluate, and report to Dietitian, physician, and responsible party of significant weight changes.</p> <p>Review of Dietary Progress Note dated 12/04/25 revealed a recommendation to add a Mighty Shake daily providing 200 kilocalories (kcal) and 6 grams (g) of protein per serving, and to obtain weekly weights for four weeks. It stated the Registered Dietician (RD) will monitor and follow up as indicated.</p> <p>Review of the Nutrition Data Collective/Evaluation assessment dated [DATE] revealed a recommendation to add Boost twice daily providing 240 kcal and 10 g protein per serving related to weight change and variable by mouth intake.</p> <p>Review of Dietary Progress Note dated 01/08/26 stated to continue weekly weights, the RD will monitor and follow up as indicated.</p> <p>Review of physician's orders revealed an order with a start date of 12/17/25 and an end date of 01/14/26 for weekly weights for four weeks every Wednesday. There was no documented evidence to support an additional/updated order for the weekly weights. Further review of orders revealed no documentation for the administration of Boost Shakes.</p> <p>Review of treatment administration record (TAR) dated 12/01/25 to 01/31/26 revealed weekly weights were completed on the following dates: 12/17/25, 12/24/25, 12/31/25, and 01/07/26. No weekly weights were documented between 01/08/26 and 01/26/26.</p> <p>Interview with Registered Dietitian (RD) #228 on 01/27/26 at 4:08 P.M. stated that their process for relaying orders to the staff was at the end of their shift they provided the Director of Nursing (DON) a paper list of their recommendations. The RD stated they provided this list for the orders and recommendations to be implemented by the DON or the unit manager. RD #228 stated the facility could also see the recommendations when they ran their 24-hour report. RD #228 stated that they would expect to see their recommendations be implemented within 24 to 48 hours of the receipt. (continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with DON #119 on 01/27/26 at 12:40 P.M. confirmed that the weekly weight order was ordered to start on 12/17/25 and delayed from the original recommendation of 12/04/25. DON #119 denied knowledge of the reason for this delay in order. DON #119 also confirmed that no weekly weight measurements were completed between 01/07/26 and 01/26/26.</p> <p>Interview with DON #119 on 01/27/26 at 3:28 P.M. revealed that the nursing staff were expected to administer the Boost shakes to residents. DON #119 confirmed that there was no documentation of administration of the Boost shakes by the nursing staff and confirmed there was no current active order for Boost shakes to be administered.</p> <p>Review of weight monitoring policy dated 10/26/23 revealed interventions will be identified, implemented, monitored and modified consistent with the resident's assessed needs, preferences, goals and current standards for nutritional status. The policy also noted a weight monitoring schedule will be developed upon admission for all residents: Resident with weight loss &ndash; monitor weekly weight.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 01/27/26 at 9:21 AM with Social Services Director (SSD) #157 revealed that when a 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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. (continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview on 01/27/2026 at 9:36 A.M. with LPN #133 was unaware of PTSD triggers for Resident #49.</p> <p>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.</p> <p>This deficiency represents noncompliance investigated under Complaint Number 2702415.</p> | | |

| | | | |
|--|--|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and record review, the facility failed to ensure that a binding arbitration agreement was explained to the resident in a form and manner the resident understood and failed to ensure the resident acknowledged understanding of the agreement prior to execution. This deficient practice affected one resident (Resident #81) out of twenty-four residents reviewed, with a facility census of 90. Findings include: Review of the medical record revealed Resident #81 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #81 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating intact cognition at the time of admission. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #81 had a BIMS score of 13 of 15, indicating the resident was cognitively intact. On 01/27/26 at approximately 12:30 PM, this surveyor interviewed Resident #81 regarding an arbitration agreement with the facility. When asked if the resident was aware of being in arbitration with the facility, Resident #81 stated this was the first time learning of an arbitration agreement. The surveyor noted that the arbitration document appeared to have been signed by the resident's spouse/partner. She stated she was alert and oriented at the time of admission and believed the facility likely provided admission paperwork to the resident's spouse/partner, who signed the documents. Resident #81 stated she would have wanted to be involved in the discussion regarding arbitration and expressed concern that the resident was not included in that process. On 01/27/26 at approximately 12:50 PM, this surveyor interviewed Admissions Personnel (AP) #104 regarding the facility's admission process and use of arbitration agreements. AP #104 stated that the facility's expectation and standard practice is that if a resident has a BIMS score of thirteen or higher, admission documents, including arbitration agreements, are reviewed directly with the resident. When asked whether Resident #81, who had a BIMS score of fifteen at admission, should have personally reviewed and signed the arbitration agreement, AP #104 stated they could not speak to why the agreement was handled differently at that admission, as they were not employed at the facility at that time and the staff involved in the admission were no longer employed. AP #104 further stated that the process described for Resident #81 would not be the procedure currently followed by admissions staff.</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**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 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 (continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| 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 02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER Arbors at Delaware | | STREET ADDRESS, CITY, STATE, ZIP CODE 2270 Warrensburg Road Delaware, OH 43015 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> | | |