

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Arbors West		STREET ADDRESS, CITY, STATE, ZIP CODE 375 West Main Street West Jefferson, OH 43162	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on observation, staff interview, resident interview, and record review, the facility failed to respond to call lights in a timely manner. This affected two residents (#35 and #49) of three reviewed for call light response. Facility census was 73.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included diabetes, spinal muscular atrophy, chronic myeloid leukemia, respiratory failure with hypoxia, pulmonary fibrosis, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact and required set up assist for eating, and was dependent with toileting, oral hygiene, showering, and personal hygiene.</p> <p>Review of the plan of care dated 10/07/24 revealed the resident require two person assistance for bed mobility and toileting.</p> <p>Observation and interview on 10/09/24 at 9:25 AM with Resident #35 revealed her call light had been on since about 8:00 A.M. for incontinence care.</p> <p>Interview on 10/09/24 at 9:27 A.M. Certified Nurse Aide (CNA) #63 confirmed the resident's call light had been activated for a long time, but she had been busy and did not have a chance to answer it. CNA revealed call lights take a long time to answer. CNA confirmed being unsure exactly how long the call light had been going off for, but revealed it was possible it was about an hour.</p> <p>Interview on 10/09/24 at 2:45 P.M. with Resident #35 revealed she would ask for showers or to get cleaned up after going to the bathroom. Resident #35 reported the response she would get from staff was they do not have time or they would say yes but then not come back or take one to two hours to return for incontinence care or answer the request.</p> <p>Interview on 10/09/24 at 3:00 P.M. with CNAs #69 and #88 revealed it was typical for long wait times for call lights. They revealed the hospitality aides were unable to help with care.</p> <p>(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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #49 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of the larynx, adult failure to thrive, chronic obstructive pulmonary disease, dysphasia and tracheostomy status.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was cognitively intact and had a feeding tube.</p> <p>Review of physician orders revealed an order dated 09/19/24 revealed Resident #49 received nutrition through tube feeding and an order dated 10/09/24 revealed the resident was NPO (no oral intake).</p> <p>Observation and interview on 10/09/24 at 9:40 A.M. with Resident #49 revealed the call light had been activated. Interview with resident revealed it had been on for a while (estimated to be about 20 minutes) and he thought the tube feeding was not working properly.</p> <p>Observations on 10/09/24 from 9:40 A.M. to 10:05 A.M. revealed several staff walking by the room with the call light left on including nursing, CNAs, the Director of Nursing (DON), and Unit Manager without response to the call light.</p> <p>Observation and interview on 10/09/24 at 10:05 A.M. with Licensed Practical Nurse (LPN) #55 revealed Resident #49's call light was activated and had been for a long time. She acknowledged all staff were responsible for answering call lights and revealed the expectation was for call lights to be answered within about five minutes.</p> <p>Review of facility policy titled, Call light policy and procedure education, undated revealed it was the facility's responsibility to take care of residents. If a call light is answered and you say you will return and do not it was a form of neglect. If you cannot assist in the services the resident requested, leave the light on and go get the appropriate help.</p> <p>Review of facility call light protocol, undated, revealed call lights shall be answered immediately, every second seems like an eternity. Everyone was responsible to answer call lights.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158116.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 44070</p> <p>Based on observation, staff interviews, and resident interviews, the facility failed to ensure residents had linens placed on their beds to ensure a comfortable homelike environment. This affected one resident (#35) of three reviewed for environment. Facility census was 73.</p> <p>Findings include</p> <p>Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included diabetes, spinal muscular atrophy, chronic myeloid leukemia, respiratory failure with hypoxia, pulmonary fibrosis, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact and required set up assist for eating, and was dependent with toileting, oral hygiene, showering, and personal hygiene.</p> <p>Review of the plan of care dated 12/10/23 revealed Resident #35 required two person assistance for bed mobility.</p> <p>Observations on 10/07/24 at 10:40 A.M., 11:10 A.M., and again at 3:30 P.M. of Resident #35's room revealed Resident #35 had no sheet on her mattress. Resident #35 had one sheet/blanket covering her while she slept.</p> <p>Observations on 10/08/24 at 1:45 P.M., 2:22 P.M., and again at 6:04 P.M. of Resident #35's room revealed the resident had no sheet on her mattress. Resident #35 had one sheet/blanket covering her while she slept.</p> <p>Observations on 10/09/24 at 9:26 A.M., 12:46 P.M., and again at 2:25 P.M. of Resident #35's room revealed the resident had no sheet on her mattress. Resident #35 had one sheet/blanket covering her while she slept.</p> <p>Interview on 10/09/24 at 2:25 P.M. with Resident #35 and Licensed Practical Nurse (LPN) #74 confirmed the resident had no sheets on her bed. Resident #35 informed LPN #74 she had asked for a sheet to be put on her bed and was told no. LPN #74 verified the type of bed and mattress resident used should have a sheet on it. He verified staff would place a sheet on the mattress.</p> <p>Interview on 10/09/24 at 3:00 P.M. with Certified Nursing Aides (CNAs) #69 and #88 revealed Resident #35 had recently moved rooms. When the resident was in her previous room, she had a sheet on her bed, but since moving a few weeks ago they had seen a mattress on resident's bed without sheets.</p>		

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<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** 44070</p> <p>Based on observation, staff and resident interviews, and record review, the facility failed to ensure residents received showers as scheduled. This affected one resident (#35) of three reviewed for Activities of Daily Living (ADLs). Facility census was 73.</p> <p>Findings include</p> <p>Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included diabetes, spinal muscular atrophy, chronic myeloid leukemia, respiratory failure with hypoxia, pulmonary fibrosis, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact and required set up assist for eating, and was dependent with toileting, oral hygiene, showering, and personal hygiene.</p> <p>Review of the shower sheet dated 08/14/24 revealed a shower was provided.</p> <p>Review of the shower sheet dated 09/02/24 revealed no mention of a shower being provided. The form stated no skin issues were found.</p> <p>Review of the shower sheet dated 09/05/24 revealed no mention of a shower being provided. The form stated no areas (skin) were found.</p> <p>Review of the shower sheet dated 09/09/24 revealed no mention of a shower being provided. The form stated no skin issues were found.</p> <p>Review of the physician order dated 09/18/24 revealed shower days were Wednesdays and Saturdays (11:00 P.M. to 7:00 A.M.).</p> <p>Review of the shower sheet dated 09/18/24 revealed a bed bath was provided. Hair and nail care was refused.</p> <p>Review of the shower sheet dated 10/02/24 revealed shower/bed bath was refused.</p> <p>Further review of the medical record revealed no additional refusals of showers/bed baths refused.</p> <p>Review of the plan of care dated 10/07/24 revealed Resident #35 had an ADL self-care performance deficit from obesity and functional quadriplegia with interventions for bed mobility of two staff, hooyer transfers, and encourage resident to use call light when assistance was needed.</p> <p>Review of the shower schedule revealed Resident #35 was marked on the scheduled for Monday/Thursday third shift, Tuesday/Friday third shift, and Wednesday/Saturday third shift. The schedule had instructions stating shower sheets were to be completed and return to the binder daily and management shall check for completion periodically.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 10/07/24 at 10:40 A.M. revealed Resident #35 appeared to be unkempt. Resident #35's hair was greasy and clumped together in stringy sections. The resident's nails were dirty with brown material underneath. Additional observations found the same cleanliness/condition at 11:10 A.M., and again at 3:30 P.M.</p> <p>Observations on 10/08/24 at 1:45 P.M., 2:22 P.M., and again at 6:04 P.M. of Resident #35 revealed she appeared in the same condition.</p> <p>Observation and interview on 10/09/24 at 2:25 P.M. with Resident #35 revealed she preferred bed baths and revealed she had asked staff and they said they did not have enough help to give her a bath. Resident #35 revealed she should get two showers/baths per week and revealed and she gets one every couple weeks. Resident stated her showers were Monday/Thursday day shift.</p> <p>Interview on 10/09/24 at 3:00 P.M. with Certified Nursing Aides (CNAs) #69 and #88 confirmed Resident #35 looked disheveled and had greasy stringy hair and dirty nails. They reported the resident refused often. They revealed a shower sheet should be filled out each time a shower/bed bath was given and refused. They revealed the resident's shower schedule was Monday/Thursday.</p> <p>Interview on 10/09/24 at 4:50 P.M. with the Director of Nursing (DON) revealed the resident's shower orders did not switch when she moved rooms and the orders stated the resident was to receive showers on Wednesday and Saturday. She was unaware the resident's schedule was marked on the binders and differed from the orders by stating the resident was scheduled Monday/Thursday, Tuesday/Friday, and Wednesday/Saturday. The DON revealed Resident #35 refused ADL care frequently. The DON also revealed the expectation was staff complete shower sheets for all showers/bed baths provided or refused and acknowledged several were missing including five missing the last half of 08/2024, four missed in 09/2024, and two missed in the first two weeks in 10/2024.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00158116, OH00158136, and OH00157590.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on observation, staff interview, and record review, facility failed to ensure residents received a full and nutritious meal. This effected one resident (#35) of three reviewed for nutritious meals. Facility census was 73.</p> <p>Findings</p> <p>Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included diabetes, spinal muscular atrophy, chronic myeloid leukemia, respiratory failure with hypoxia, pulmonary fibrosis, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact and required set up assist for eating.</p> <p>Review of the plan of care dated 12/10/23 revealed resident was at risk for altered nutritional status with interventions to provide meals based on food preferences and as ordered update preferences on the tray ticket.</p> <p>Review of physician orders for 08/26/24 revealed an order for carb controlled diet.</p> <p>Review of the menu spread sheet for dinner meal on 10/08/24 revealed carb controlled diet should be provided 3/4 cup of lentil soup, two whole wheat crackers, two oz of tuna salad on one slice of wheat bread, marinated tomato salad, 1/2 of a slice of dessert.</p> <p>Review of the menu ticket dated 10/08/24 for dinner revealed no mention of Resident #35 not liking soup or the resident should not receive soup.</p> <p>Observation on 10/08/24 at 6:04 P.M. revealed staff passed dinner tray to Resident #35. Resident #35 asked what was served for dinner and was told it was shredded lettuce with tomato and onion salad and two slices of lunch meat on the plate. Resident was heard stating, That's all they sent? I will just order food on door dash.</p> <p>Interview on 10/08/24 at 6:06 P.M. with Certified Nurse Aide (CNA) #118 confirmed Resident #35 received lettuce, lunch meat, and tomato salad with no bread or soup and crackers. CNA #118 revealed the resident did not like bread and would get sandwiches as open face style.</p> <p>Interview on 10/08/24 at 6:25 P.M. with Director of Nursing revealed no knowledge of why Resident #35 was missing several food items including half of her meal (soup).</p> <p>Interview on 10/09/24 at 10:10 A.M. with Kitchen Manager (KM) #57 revealed Resident #35 had a lot of preferences and revealed she did not like bread or tuna. KM #57 revealed he had spoken with the resident and she liked soups. KM #57 confirmed the resident was not given half of her meal and stated the resident typically called door dash. KM #57 acknowledged that Resident #35 could be ordering door dash because she is getting partial meals.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/09/24 at 2:45 P.M. with Resident #35 revealed she liked fish/tuna and liked soups. She revealed she would prefer sandwiches made into wraps instead of a pile of food on a plate. Resident #35 reported when she was told what the meal was for dinner 10/09/24 she knew it wasn't much to eat and revealed she ended up ordering door dash so she had a full meal.</p> <p>Review of facility policy titled, Menus and Adequate Nutrition, dated 01/01/22 revealed menus shall be developed to meet resident nutritional needs using established guidelines. Menus shall be followed as as posted.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157590.</p>		