| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365474 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Carroll | 3680 Dolson Court NW<br>Carroll, OH 43112 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and review of the facility policy, the facility failed to ensure Resident #3 was treated with dignity when his indwelling urinary catheter collection bag was not covered and was visible from the hallway. This affected one (Resident #3) of one resident reviewed for catheters. The facility census was 91. Findings include: Review of Resident #3's medical record revealed the resident was initially admitted to the facility on [DATE] and re-admitted to the facility 12/23/25. Resident #3 had diagnoses that included morbid (severe) obesity with alveolar hypoventilation, obstructive and reflux uropathy, major depressive disorder, retention of urine unspecified, hydronephrosis with ureteral stricture, and overactive bladder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact and had an indwelling catheter. Review of the care plan dated 08/25/25 revealed Resident #3 had an indwelling catheter related to obstructive uropathy with interventions that included privacy cover to catheter drainage bag. Observation of Resident #3 on 03/02/26 at 11:40 A.M. revealed the indwelling urinary catheter bag was hanging on the left side of the resident's bed. A privacy cover was not in place, and urine was visible in the collection bag from the hallway. Observation of Resident #3 on 03/03/26 at 7:41 A.M. revealed the indwelling urinary catheter bag was hanging on the left side of the resident's bed. A privacy cover was not in place, and urine was visible in the collection bag from the hallway. Observation of Resident #3 on 03/03/26 at 5:28 P.M. revealed the indwelling urinary catheter bag was hanging on the left side of the resident's bed. A privacy cover was not in place, and urine was visible in the collection bag from the hallway. Interview with Nursing Certified Nursing Assistant (CNA) #147 on 03/03/26 at 5:28 P.M. confirmed Resident #3's indwelling urinary catheter bag did not have a privacy cover and urine was visible in the collection bag from the hallway. Review of the policy titled Catheter Care Procedure - Urinary, implemented 10/30/20 and reviewed/revised on 12/28/23, revealed privacy bags are used to cover catheter drainage bags while in use. |

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

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

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|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview, and facility policy review, the facility failed to provide privacy while incontinence care was provided. This affected one resident (#22) of one resident reviewed for bowel and bladder. The facility census was 91. Findings Include:Review of the medical record for Resident #22 revealed an initial admission date of 01/06/23 with diagnoses including cerebrovascular accident with left sided hemiplegia, dementia, convulsions, diabetes mellitus, chronic kidney disease, dysphagia, seizures, peripheral vascular disease, celiac artery compression syndrome, hypertension, insomnia and anxiety disorder.Review of the plan of care dated 10/11/23 revealed the resident had bowel and bladder incontinence related to impaired mobility and physical limitations. Interventions included assist the resident with toileting needs, check at regular intervals and change as needed, and provide perineal (peri) care after each incontinent episode and apply house barrier cream after incontinence care.Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit and was dependent upon staff for toileting. The assessment indicated the resident was always incontinent of bladder and frequently incontinent of bowel. Review of the resident's monthly physician orders for March 2026 identified orders dated 12/17/25 to offer bed pan every two hours, check and change every two hours and on 03/03/26 the resident was ordered zinc cream to buttocks/peri-area as needed for itching every one hour as needed.An observation on 03/03/26 at 3:46 P.M. revealed Licensed Practical Nurse (LPN) #155 provided incontinence care for Resident #22. The LPN provided incontinence care with the window blind open, facing another wing of the facility within view of other resident's windows with open blinds. An interview on 03/03/26 at 4:08 P.M. with LPN #155 verified the resident's window blind was not closed for privacy during the incontinence care allowing the adjacent hallway resident rooms to potentially view into Resident #22's room.Review of the facility policy titled, Resident Rights Implementation, last revised on 01/01/22 revealed for any procedure that involves direct care, follow these steps, including to close the room entrance door and provide for the resident's privacy. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview, and facility policy review, the facility failed to provide off-loading (a critical technique used to reduce pressure on specific areas of the body, particularly in wound care) for a stage III pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include tunneling or undermining). This affected one resident (#21) of one resident reviewed for pressure ulcers. The facility census was 91.Findings Include:Review of the medical record for Resident #21 revealed an initial admission date of 09/19/22 with the latest readmission date of 02/04/26 with diagnoses including but not limited to chronic obstructive pulmonary disease, acute and chronic respiratory failure, congestive heart failure, malignant neoplasm of bladder, peripheral vascular disease, morbid obesity, neuropathy, pain, anxiety disorder, gastro-esophageal reflux disease, benign prostatic hyperplasia with lower urinary tract symptoms, edema, psoriasis, major depressive disorder, obstructive sleep apnea, anemia and hyperlipidemia.Review of the plan of care dated 05/27/25 revealed the resident had impaired skin integrity as evidenced by generalized/scattered bruising, stage III pressure to the left heel related to needing assistance with Activities of Daily Living (ADLs), neuropathy, peripheral vascular disease diagnosis. Interventions included administer treatments per orders, assist resident with turning and repositioning as needed, complete skin inspections weekly and as needed, complete wound evaluation to observe the progress of the resident's skin condition, consult dietitian as needed, dietary supplement as ordered, encourage good nutrition and hydration, assist as needed, encourage resident to reposition self if able, encourage/assist as needed to elevate heels off the mattress as tolerated, notify nurse of any new areas of skin impairment noted during bathing or daily care, notify physician of noted worsening skin conditions or any new areas of skin impairment, notify physician of signs/symptoms of infection, periodically complete Braden Scale, pressure redistribution device in chair, pressure redistribution mattress to bed, provide incontinence care, and therapy screen, evaluation, treatment as needed.Review of the resident's Braden scale dated 01/23/26 revealed a score of 20 indicating the resident was at low risk for skin breakdown.Review of the resident's significant change MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident was at risk for skin breakdown and had one unhealed stage III pressure ulcer present on admission. The facility implemented the interventions of pressure reducing device to bed/chair, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care and applications of ointments/medications other than to feet.Review of the initial weekly skin issue assessment dated [DATE] revealed the resident was readmitted to the facility with a stage III pressure ulcer to the left lateral heel measuring 2.56 centimeters (cm) by 2.12 cm by zero depth and described as having epithelial and granulation tissue as well as slough and eschar with no odor, however the wound was documented as having odor after cleansing the wound. Further review of the assessment revealed no documentation determining how much of the wound was slough and how much was eschar. Review of the Wound Nurse Practitioner (WNP) progress note dated 02/10/26 revealed the stage III pressure ulcer measured 0.5 cm by 0.5 cm by 0.1 cm with 100% pink wound base with a scant amount of serosanguinous exudate. The peri-wound was described as being dry with flaking skin. The WNP documented the previously healed stage III pressure ulcer had reopened this past week as the resident returned to the facility from hospitalization. The wound was described as being a healing stage III pressure ulcer. The WNP initiated the treatment to cleanse with normal saline, apply betadine soaked gauze, cover with an abdominal (ABD) pad and wrap with kerlex three times a week and as needed. The staff was educated on the importance of offloading to promote wound healing. Review of the WNP progress note dated 02/17/26 revealed the stage III pressure ulcer measured 0.5 cm by 0.6 cm by 0.1 cm with 100% pink wound base with a scant amount<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of serosanguinous exudate. The peri-wound was described as being dry with flaking skin. The WNP determined the wound was unchanged and determined the wound was similar in size and appearance as on 02/10/26 and continued the current treatment.Review of the WNP progress note dated 02/24/26 revealed the stage III pressure ulcer measured 0.6 cm by 0.3 cm by 0.1 cm with 100% pink wound base with a scant amount of serosanguinous exudate. The peri-wound was described as being dry with flaking skin. The WNP determined the wound was unchanged and determined the wound was similar in size and appearance as on 02/17/26 and implemented the treatment to cleanse with normal saline, apply collagen, cover with ABD pad, and wrap with Kerlex daily and as needed. Review of the WNP progress note dated 03/03/26 revealed the stage III pressure ulcer measured 0.6 cm by 0.5 cm by 0.1 cm with 100% pink wound base with a moderate amount of serosanguinous exudate. The peri-wound was described as being dry with flaking skin, macerated and moist. The WNP determined the wound was unchanged and determined the wound was similar in size and appearance as on 02/24/26, however, increased exudate was noted on examination, with moisture and maceration present in the peri-wound area. The facility implemented the treatment cleanse with normal saline, apply collagen to wound bed, cover collagen with calcium alginate, cover with ABD pad, and wrap with Kerlex daily and as needed. On 03/02/26 at 12:13 P.M. an observation and interview with Resident #21 revealed he had stage III pressure ulcer to his left heel. Observation of the resident revealed there was no off-loading while sitting up in his wheelchair. Further observation revealed the resident's left heel was resting on the floor with no off-loading to the wound.On 03/03/26 at 2:30 P.M., an observation of Resident #21 revealed he was sitting up in his wheelchair in his room watching television with his left heel resting on the floor providing no off-loading to the stage III pressure ulcer.On 03/04/26 at 10:15 A.M., an observation of Resident #21 revealed the resident's left heel was resting on the floor providing no off-loading to the stage III pressure ulcer. On 03/04/26 at 11:49 A.M., an interview with the Director of Nursing (DON) verified the resident had no off-loading to the stage III pressure ulcer to the left heel while sitting up in his wheelchair. On 03/04/26 at 12:31 P.M., an observation of Resident #21's stage III pressure ulcer to left heel with Registered Nurse (RN) #124 and Certified Medication Technician (CMT) #159 revealed the residents wound was the size of a quarter with pink tissue. The surrounding tissue was white and moist in color. Review of the facility policy titled, Wound Treatment Management, last revised on 10/26/23 revealed it was the policy of the facility to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician ordered. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to provide timely podiatry care for Residents #30 and #51. This affected 2 residents (#30 and #51) of 9 residents reviewed for activities of daily living. The facility census was 91.Findings Include:1. Record review for Resident #30 revealed the resident was admitted to the facility on [DATE] with diagnoses including: spinal stenosis, diabetes mellitus, hypertension, hyperlipidemia, osteoarthritis, muscle weakness, cognitive communication deficit, major depressive disorder.Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #30 was dependent on staff for personal hygiene.Further review of the medical record revealed Resident #30 was last seen by podiatry services in the facility on 10/21/25. Observation and interview on 03/02/26 at 3:42 P.M. with Resident #30 revealed she had long toenails that were hanging over the skin. The resident confirmed she would like her toenails cut. She affirmed she previously notified an unknown staff member about the need for her toenails to be cut. 2. Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] with diagnoses including: acute respiratory failure with hypoxia, Crohn's disease, end stage renal disease, muscle weakness, generalized anxiety, osteoarthritis, and congestive heart failure. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 was dependent on staff for personal hygiene.Observation and interview on 03/02/26 at 3:42 P.M. with Resident #51 revealed she had an ingrown toenail and her toenails were so long they were hanging over the skin. Resident #51 stated her toenails were so long that they were causing her pain when wearing shoes.During an interview with Social Services Director (SSD) #120 on 03/04/26 at 9:51 A.M. confirmed podiatry had not visited the facility since 10/21/25, so Resident #51 had not been seen by podiatry in the facility yet. The next visit was scheduled for 03/17/26. SSD #120 confirmed both Resident #30 and #51 were to have their toenails clipped by podiatry services. During an interview on 03/04/26 at 10:51 A.M. with the Director of Nursing (DON) confirmed that podiatry would typically trim toenails for the residents. She agreed it had been an extended period since the last toenail trims had occurred.Review of the facility's policy Nail Care revised 08/20/24 revealed routine nail care will be provided for residents on a regularly and as needed basis. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, staff and resident interviews, medical record review, and review of facility policy on dental services, the facility failed to ensure residents received timely dental services related to dentures. This affected one (#3) of three residents reviewed for dental. The facility census was 91.Findings include:Review of the medical record for Resident #3 revealed the resident was admitted to the facility on [DATE] and re-admitted to the facility 12/23/25. Resident #3 had diagnoses that included chronic respiratory failure unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease unspecified, type 2 diabetes mellitus without complications, chronic diastolic (congestive) heart failure, chronic kidney disease stage 3, morbid (severe) obesity with alveolar hypoventilation, obstructive and reflux uropathy, major depressive disorder, dysphagia, retention of urine unspecified, dependence on supplemental oxygen, atherosclerotic heart disease of native coronary artery without angina pectoris, obstructive sleep apnea, venous insufficiency, hypothyroidism, restless leg syndrome, hydronephrosis with ureteral stricture, and overactive bladder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact and did not exhibit any physical, verbal, other behavioral symptoms, or rejection of care. Resident #3 had mouth or facial pain, and discomfort or difficulty with chewing.Review of the care plan dated 08/18/25 revealed Resident #3 was at risk for dental problems related to no natural teeth with interventions that included refer to dental services as needed.Review of dental progress notes dated 12/14/23 revealed impressions were obtained for dentures.Review of dental progress note dated 02/12/24 revealed upper and lower dentures were seated and fit well. Review of dental progress notes dated 07/01/25 revealed prior authorization for full dentures was submitted.Review of progress notes revealed no further documentation or follow up on the full dentures prior authorization. Observation of Resident #3 on 03/02/26 at 11:40 A.M. revealed Resident #3 was not wearing upper or lower dentures.Interview with Resident #3 on 03/02/26 at 11:40 A.M. revealed Resident #3 could not find the lower dentures. Resident #3 was unable to report when the lower dentures were lost and reported difficulty chewing at times.Interview with Social Services Director #120 on 03/03/26 at 2:10 P.M. revealed Resident #3 was last seen by the dentist on 07/01/25. Social Services Director #120 revealed Resident #3 consented to dentures at that visit and should be fit for dentures at the next dental appointment scheduled July 2026. She confirmed the residents bottom dentures were lost and also confirmed that a year between the prior authorization in July of 2025 and the fitting scheduled for July of 2026 was not considered timely. Review of the facility policy titled Dental Services implemented 10/18/20 and reviewed/revised 10/30/23 revealed social services will assist the resident or representative in making dental appointments and applying for dental reimbursement. Further review of the policy revealed the facility will promptly refer residents with lost or damaged dentures for dental services and service staff/dietary manager or designee will document what was done to ensure the resident could eat and drink adequately while awaiting dental services and will describe the extenuating circumstance around the delay. Additionally, the facility shall not charge a resident for the loss or damage of dentures when it is determined to the facility's responsibility. |