

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Woodsfield		STREET ADDRESS, CITY, STATE, ZIP CODE 37930 Airport Road Woodsfield, OH 43793	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47985</p> <p>Based on observation and interview, the facility failed to ensure all residents received a dignified dining experience when residents seated at a table were not served their meals at the same time. This affected four residents (#2, #8, #47, and #161) of 20 residents observed in the dining room. The facility census was 55.</p> <p>Findings included:</p> <p>Observation on 04/08/24 at 11:09 A.M. revealed Residents #2, #8, #47, and #161 were seated at a table together. Throughout the dining process, the following was observed:</p> <ul style="list-style-type: none"> -11:09 A.M. Resident #8 received her meal, staff then began to serve other tables. -11:19 A.M. Resident #47 received a bowl of soup. -11:22 A.M. Resident #2 received her tray. -11:26 A.M. Resident #161 received her tray. <p>Interview on 04/08/24 at 11:30 A.M. with Registered Nurse (RN) #135 revealed each table should be served at a time. RN #135 confirmed the above findings.</p> <p>Interview on 04/11/24 at 5:23 P.M. with Resident #47 revealed a lot of times, the residents at lunch tables are not served at the same time. Resident #47 stated it is frustrating and upsetting to be seated at a table with other residents who are eating when she doesn't have her tray because she gets hungry or feels bad when she is served before others.</p> <p>Review of a policy titled Promoting/Maintaining Resident Dignity (dated 10/26/23) revealed it is the policy of the facility to protect and promote resident rights and dignity. All staff members involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on medical record review and interview, the facility failed to ensure baseline care plans were developed and/or summaries of the baseline care plan were provided to the residents and their representatives. This affected five residents (#20, #24, #46, #58 and #263) of 23 residents whose care plans were reviewed.</p> <p>Findings include:</p> <p>1. Review of Resident #58's medical record revealed diagnoses including left artificial shoulder joint, osteoarthritis of the left shoulder, morbid obesity, stage three chronic kidney disease, Stage two (shallow) pressure ulcer of the left heel, hypertension, generalized muscle weakness, difficulty walking, anxiety disorder, depressive disorder, vitamin D deficiency, hyperlipidemia, osteoarthritis of bilateral knees and of the right hip.</p> <p>Review of Resident #58's nursing admission assessment dated [DATE] revealed as needs or risks were identified the facility identified interventions to be implemented. There was no evidence the facility discussed the baseline care plan or provided a summary of it to Resident #58 and/or a representative.</p> <p>An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #58 was able to understand others. Resident #58 was assessed as cognitively intact with a Brief Interview of Mental Status (BIMS) score of 14 (out of 15 possible points).</p> <p>During an interview on 04/10/24 at 4:09 P.M., Social Service Director/Designee (SSD) #126 provided a discharge planning evaluation dated 03/11/24 which she stated was a care plan meeting. The discharge planning evaluation addressed information such as the reason for admission, type of stay, expectations for the stay, discharge plan, a review of types of equipment Resident #58 had available to her upon discharge, and environmental barriers to discharge. The form indicated topics discussed also included activities, activities of daily living/rehab, and mood/behavior. The form contained an area to specify who was provided a copy of the care plan and it indicated it was na (not applicable). SSD #126 verified Resident #58 was not provided with a written summary of the baseline care plan.</p> <p>2. Review of Resident #263's medical record revealed diagnoses including congestive heart failure (CHF), type two diabetes mellitus, hypertensive heart disease, pressure ulcer of the left heel, hyperlipidemia, depression, peripheral vascular disease, and generalized muscle weakness.</p> <p>Review of nursing admission evaluation dated 03/28/24 revealed interventions were initiated for identified areas of concerns/risks. There was no documentation of Resident #263 receiving a summary of the baseline care plan.</p> <p>On 04/10/24 at 4:09 P.M., SSD #126 provided a Discharge Planning Evaluation dated 03/29/24 which had an area to summarize the discussion of the care plan conference which indicated there was none. The form also indicated a copy of the care plan was not provided to anybody. SSD #126 verified a written summary of the baseline care plan was not provided to Resident #263.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47985</p> <p>3. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis, type II diabetes, acute kidney failure, and major depressive disorder. Review of MDS completed on 01/24/24 revealed Resident #20 had moderately impaired cognition.</p> <p>Record review revealed no evidence a baseline care plan was completed within 48 hours of admission or that a copy was given to Resident #20.</p> <p>Interview on 04/10/24 at 2:29 P.M. with Social Services Director (SSD) #126 revealed care conferences should be completed upon admission, annually, quarterly, and for significant changes. SSD #126 stated after a resident admits, the timing of the care conference depends on family availability but most of the time she meets with the resident to give baseline care plans if they want to have a copy. SSD #126 stated care conferences could be located in the assessment tab in PointClickCare.</p> <p>Request for baseline care plan was made to Administrator on 04/11/24 at 11:53 A.M. with no response.</p> <p>4. Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, hydronephrosis, and cognitive communication deficit. Review of a quarterly MDS completed on 02/06/24 revealed Resident #24 had mildly impaired cognition.</p> <p>Record review revealed no evidence a baseline care plan was completed or given to Resident #24 within 48 hours of admission.</p> <p>Interview on 04/10/24 at 2:29 P.M. with Social Services Director (SSD) #126 revealed care conferences should be completed upon admission, annually, quarterly, and for significant changes. SSD #126 stated after a resident admits, the timing of the care conference depends on family availability but most of the time she meets with the resident to give baseline care plans if they want to have a copy. SSD #126 stated care conferences could be located in the assessment tab in PointClickCare.</p> <p>Request for baseline care plan was made to Administrator on 04/11/24 at 11:53 A.M. with no response.</p> <p>5. Record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, type II diabetes, panic disorder, and post traumatic stress disorder. Review of quarterly MDS completed on 01/17/24 revealed Resident #46 had moderately impaired cognition.</p> <p>Record review revealed no evidence a baseline care plan was completed or given to Resident #46 within 48 hours of admission.</p> <p>Interview on 04/10/24 at 2:29 P.M. with Social Services Director (SSD) #126 revealed care conferences should be completed upon admission, annually, quarterly, and for significant changes. SSD #126 stated after a resident admits, the timing of the care conference depends on family availability but most of the time she meets with the resident to give baseline care plans if they want to have a copy. SSD #126 stated care conferences could be located in the assessment tab in PointClickCare.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Request for baseline care plan was made to Administrator on 04/11/24 at 11:53 A.M. with no response.</p> <p>Review of a policy titled Baseline Care Plan (dated 12/28/23) revealed a baseline care plan should be developed within 48 hours of a resident's admission, should include the minimum healthcare information necessary to properly care for a resident including but not limited to initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and Pre-Admission Screening recommendations if applicable. The baseline care plan should be used until staff conducts the comprehensive assessment and develop an interdisciplinary comprehensive care plan. The facility should provide the resident and their representative with a summary of the care plan that includes but is not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, and any updated information based on the details of the comprehensive care plan as necessary.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on record review and interviews, facility failed to conduct care conferences with residents in conjunction with minimum data set (MDS) assessments. This affected two residents (#24 and #49) of three residents reviewed for care planning. The facility census was 55.</p> <p>Findings included:</p> <p>1. Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, and cognitive communication deficit. Review of a quarterly MDS revealed Resident #24 had mildly impaired cognition.</p> <p>Record review revealed Resident #24 had a discharge planning meeting with the social worker on 05/24/23, a care conference on 06/02/23, 09/20/23, 11/27/23, and a letter inviting them to a care conference on 01/24/24 but no record of the care conference being completed.</p> <p>Interview on 04/08/24 at 4:08 P.M. with Resident #24 revealed they had not had a care conference or been able to make decisions regarding treatment.</p> <p>Interview on 04/11/24 at 9:50 A.M. with Social Services Director (SSD) #126 revealed the admission care conference should be under an assessment called Discharge Planning Evaluation. SSD #126 confirmed the initial care conference was opened on 05/05/23 but completed on 05/09/23 and the interdisciplinary team was not included in the care conference.</p> <p>2. Record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis, neoplasm of unspecified behavior of bladder, chronic obstructive pulmonary disease, and atrial fibrillation. Review of a quarterly MDS revealed Resident #49's cognition remained intact.</p> <p>Record review revealed Resident #49 had a care conference on 07/28/23. Review of letters provided by SSD #126 revealed Resident #49 was invited to care conferences for 10/10/23 and 02/26/24 but no evidence was provided to show care conference were completed.</p> <p>Interview on 04/08/24 at 10:14 A.M. with Resident #49 revealed he was not invited to participate in care conferences.</p> <p>Interview on 04/10/24 with SSD #126 revealed care conferences are done upon admission, annually, quarterly, and with significant changes. SSD #126 stated she worked with the MDS nurse on scheduling care conferences who keeps a calendar of when residents are due for quarterly and annual assessments, then would send letters to invite resident and family members to care conferences. SSD #126 stated upon admission, the timing of the admission care conference depended on the availability of family members but the facility would still meet with the resident within the first 48 hours to start discharge planning. SSD #126 stated residents only get copies of care plans if they wanted them. SSD #126 stated Resident #49 should have had a care conference in February 2024 but was not able to find documentation and should have had one in October 2023 as well.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a policy titled Comprehensive Care Plans (dated 06/30/22) revealed every effort should be made to schedule a care plan meeting at the best time of the day for the resident and family, and when a resident has no family, the ombudsman may be invited to attend the care plan meeting if desired by the resident.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>22653</p> <p>Based on medical record review and interview, the facility failed to ensure recommendations for restorative ambulation programs were implemented to maintain a resident's ambulatory status. This affected one resident (#37) of three residents reviewed for activities of daily living.</p> <p>Findings include:</p> <p>During an interview on 04/09/24 at 9:03 A.M., Resident #37 stated she used to ambulate with therapy. However, she had not received assistance with walking for weeks and felt she was getting weaker.</p> <p>Review of Resident #37's medical record revealed diagnoses including degenerative disease of the nervous system, peripheral vascular disease, malignant neoplasm of the right breast, type two diabetes mellitus with neuropathy, osteoporosis, macular degeneration, abnormalities of gait and mobility, difficulty walking and generalized muscle weakness.</p> <p>A Physical Therapy (PT) evaluation dated 11/02/23 indicated Resident #37 was referred to PT due to new onset of falls/fall risk, decrease in functional mobility, functional limitation with ambulation, reduced static balance, reduced dynamic balance, decrease in strength, increased need for assistance from others and reduced activity of daily living (ADL) participation. The PT evaluation Indicated Resident #37 had recently suffered a fall when ambulating to the bathroom with no injuries reported. Resident #37 reported her knee buckled on her while ambulating. At baseline, Resident #37 ambulated 50 feet using a rolling walker and minimal assist. A PT discharge summary dated 12/01/23 indicated Resident #37 met a goal to safely ambulate 100 feet using the most appropriate assistive device and contact guard assistance (CGA). The summary indicated Resident #37 progressed well demonstrating improvements in functional strength and mobility. A restorative ambulation program was established for ambulation 100 feet with upright walker and CGA. Prognosis to maintain her current level of function was excellent with consistent staff support.</p> <p>A Therapy to Restorative Nursing Communication - Resident Status Update form dated 01/05/24 indicated plans for a restorative ambulation program for Resident #37 to ambulate 100 feet with stand by assist and use of an upright walker.</p> <p>A PT evaluation dated 02/06/24 indicated Resident #37 was referred for evaluation and treatment following a fall. The prior level of function when discharged from therapy was ambulating 100 feet with CGA. During the evaluation Resident #37 was able to walk 50 feet with CGA. The evaluation indicated Resident #37 felt unsteady when standing and when walking and was worried about falling. A PT discharge summary dated 03/06/24 indicated Resident #37 met a goal of walking 100 feet with CGA on 02/22/24. The summary indicated Resident #37 progressed well demonstrating improvements in functional strength and mobility. A restorative ambulation program was established for ambulating 100 feet with CGA.</p> <p>A therapy quarterly screen dated 04/08/24 indicated Resident #37 was requesting therapy services to improve strength and balance to improve functional mobility and reduce fall risk. PT was recommended.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/24 at 3:00 P.M., Registered Nurse (RN) #132 (restorative nurse) stated she had not received a referral for restorative nursing program for Resident #37 since September 2023. When Resident #37 was placed on therapy caseload for ambulation the restorative ambulation programs were discontinued.</p> <p>During an interview on 04/10/24 at 11:50 A.M., Physical Therapy Assistant (PTA)/rehab manager #400 provided a copy of the restorative referral for an ambulation program dated 01/05/24. PTA #400 stated it was an oversight of therapy not to complete a new referral to restorative nursing when PT ended 03/06/24 but assumed the program recommended 01/05/24 would resume.</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** 47985</p> <p>Based on medical record review, observation, and interview, the facility failed to provide oral care for a resident who is dependent on staff for personal care. This affected one resident (#46) of two residents reviewed for activities of daily living (ADL). The facility census was 55.</p> <p>Findings included:</p> <p>Record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, type II diabetes, panic disorder, post traumatic stress disorder, and fibromyalgia.</p> <p>Review of a quarterly minimum data set (MDS) completed on 01/17/24 revealed Resident #46 was dependent on staff for completing all activities of daily living.</p> <p>Review of a care plan dated 10/23/23 revealed Resident #46 had an ADL self-care performance deficit related to Alzheimer's disease, dementia, and a history of falls. Goals included residents ADL needs would be met through the next review with interventions including two person assist for personal hygiene, encouraging participation in daily care and providing positive reinforcement for activities attempted and/or partially achieved, and providing cues and assist as needed to accomplish daily tasks. A dental care plan revealed Resident #46 had potential for dental problems related to age with a goal of having good oral hygiene habits through the next review and intervention including providing medication and/or treatment as ordered.</p> <p>Interview on 04/08/24 at 4:45 P.M. with Resident #46's representative revealed at times, Resident #46 has bad breath and he did not believe her teeth were brushed.</p> <p>Observation on 04/09/24 at 12:46 P.M. revealed Resident #46 was resting in bed. When asked if her teeth had been brushed, Resident #46 shook her head no. When asked to see her teeth, Resident #46 smiled and revealed her teeth had a layer of plaque and grime.</p> <p>Observation on 04/09/25 at 3:13 P.M. revealed Resident #46 was seated in the hallway in her wheelchair. When asked if her teeth had been brushed, Resident #46 shook her head no and showed her teeth which continued to have a layer of plaque and grime.</p> <p>Interview on 04/11/24 at 12:57 P.M. with State tested Nursing Assistant (STNA) #134 revealed oral care should be completed on residents who can't brush their own teeth in the morning, evenings, and as needed. Oral care should be completed daily on residents who are dependent upon staff. STNA #134 stated Resident #46 was dependent upon staff for oral care and hygiene.</p> <p>Interview on 04/11/24 at 1:16 P.M. with STNA #134 confirmed Resident #46's teeth had plaque and build up on them and confirmed Resident #46 shook her head no when asked if oral care had been completed and nodded her head yes when asked if she wanted oral care to be completed. STNA #134 stated even though Resident #46 does not speak often, she is able to accurately answer questions by shaking or nodding her head.</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>A policy for oral care was requested on 04/11/24 at 2:52 P.M. from Administrator but was not received.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on observation, record review and interview, the facility failed to ensure interventions to prevent pressure ulcers were in place per orders. This affected one resident (#39) of two residents reviewed for pressure ulcers. The facility census was 55.</p> <p>Findings included:</p> <p>Record review revealed Resident #39 admitted to the facility on [DATE] with diagnoses including heart failure, type II diabetes, chronic obstructive pulmonary disease, atrial fibrillation, and dementia.</p> <p>Review of orders revealed Resident #39 had orders in place for an alternating air mattress (01/08/24) and zero gravity boots to bilateral feet while in bed (starting on 02/01/23 and discontinued on 04/08/24).</p> <p>Review of care plan dated 12/31/23 revealed Resident #39 is at risk for impaired skin integrity related to confined to a bed all or most of the time, dementia, diabetes, incontinent of bladder, incontinent of bowel, needs assistance with activities of daily living, palliative care, peripheral vascular disease diagnosis, and skin break down to coccyx. Interventions included skin prep to bilateral heels, turn and reposition as tolerated and preventative treatments as ordered.</p> <p>Review of a quarterly minimum data set completed on 01/25/24 revealed Resident #39 required maximum assistance for bed mobility and had pressure reducing devices in bed.</p> <p>Observation on 04/08/24 at 10:34 A.M. revealed Resident #39 was resting in bed with an alternating air mattress in place and zero gravity boots were noted to be on her dresser.</p> <p>Observation on 04/08/24 at 4:14 P.M. revealed Resident #39 was in bed and her zero gravity boots were on her dresser.</p> <p>Interview on 04/08/24 at 4:15 P.M. with Registered Nurse (RN) #110 verified Resident #39 should have her zero gravity boots on while resting in bed.</p> <p>Review of a policy titled Pressure Ulcer/Skin Breakdown - Clinical Protocol (dated 03/20/24) revealed based on the comprehensive assessment of a resident, a resident receives care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable. The plan of care for prevention and/or treatment of pressure ulcers will be developed based on the assessments to include but not limited to support surfaces, turning schedule/off-loading, moisture management, incontinence management, nutritional management, pain management, disease effects of perfusion and/or healing, medications that may effect perfusion and/or healing. The physician will authorize pertinent orders related to wound treatments including pressure reduction surfaces.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923</p> <p>Based on record review, observation, and staff interview, the facility failed to implement fall prevention interventions for a resident with a history of falls. This affected one resident (#27) of three residents reviewed for accidents.</p> <p>Findings include:</p> <p>Review of Resident #27's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a stroke with hemiplegia (paralysis) and hemiparesis (weakness) affecting her left non-dominant side, unspecified convulsions, Alzheimer's disease, vascular dementia, severe intellectual disabilities, muscle weakness, unsteadiness on her feet, and difficulty walking.</p> <p>Review of Resident #27's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was severely impaired. She had a functional limitation in her range of motion on one side of her upper and lower extremity. She had one fall since the prior assessment that was without injury.</p> <p>Review of Resident #27's plan of care revealed she had a care plan in place for being at risk for falls. The interventions included the need for her to be in a low bed when not providing care. That intervention had been revised on 10/12/23. Her physician's orders also included the need for a low bed when not providing care with that order originating on 02/03/23.</p> <p>Review of Resident #27's progress notes revealed her last fall occurred on 01/06/24 at 5:54 A.M. She was found lying on the floor on the mat that was next to her bed. Her bed was indicated to be in its lowest position with no injuries occurring as a result of that fall.</p> <p>On 04/08/24 at 1:40 P.M., an observation of Resident #27 noted her to be lying in bed. Her bed was not noted to be in its lowest position and staff were not in the room providing care.</p> <p>On 04/10/24 at 2:26 P.M., further observation of Resident #27 noted her again in bed with the bed not in its lowest position. Staff were not in the room providing any care to the resident at the time the observation was made.</p> <p>On 04/10/24 at 2:45 P.M., an observation was made of Resident #27 still in bed with her bed not in its lowest position. The bed frame was off the floor about 12 inches and the resident was on a deep perimeter pressure reduction mattress on top of that. Findings were confirmed with Licensed Practical Nurse (LPN) #107.</p> <p>On 04/10/24 at 2:47 P.M., an interview with LPN #107 confirmed Resident #27's bed should be maintained in its lowest position when not receiving care as per her physician's orders and care plan. She lowered the resident's bed by about six inches so it was closer to the floor. She said she was not able to lower it further due to the bed being able to be moved when it was in its lowest position and the [NAME] wheels were in contact with the floor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Woodsfield		STREET ADDRESS, CITY, STATE, ZIP CODE 37930 Airport Road Woodsfield, OH 43793	
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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653</p> <p>Based on observation, medical record review, review of menus, and interview, the facility failed to ensure food was palatable. This affected four residents (#37, #49, #58 and #263) of six residents reviewed for food concerns and one additional resident (Resident #36).</p> <p>Findings include:</p> <p>1. Review of Resident #58's medical record revealed diagnoses including heart failure and stage three chronic kidney disease. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #58 was cognitively intact and able to make herself understood.</p> <p>On 04/08/24 at 11:54 A.M., Resident #58's lunch was served. Potatoes were dark brown on all sides except two potatoes which had one lighter brown side. Resident #58 tapped her fork on the potatoes and it made a sound as if scraping burned toast. Resident #58 reported the potatoes were hard. As Resident #58 attempted to get one of the potatoes on a fork it and another potato left the plate and landed on the over the bed table. Resident #58 reported the green beans were not seasoned (no evidence of seasoning was noted with observation) according to the meal ticket.</p> <p>Review of the menu for 04/08/24 for lunch revealed menu items included marinated chicken thigh, seasoned green beans, potato wedges, dinner roll/bread, and chocolate cake with peanut butter frosting.</p> <p>On 04/08/24 at 12:00 P.M., Cook #405 stated there were no potatoes or green beans left over to taste. Cook #405 stated she thought the potatoes looked dark but denied they felt hard on the tray line.</p> <p>On 04/08/24 at 12:29 P.M. State tested Nursing Assistant (STNA) #122 was observed picking up trays and stated nobody was really eating the potatoes and stated the potatoes appeared burnt.</p> <p>2. Review of Resident #36's medical record revealed diagnoses including orthostatic hypotension and history of malignant neoplasm of the kidney. A quarterly MDS dated [DATE] indicated Resident #36 was cognitively intact.</p> <p>On 04/08/24 at 12:21 P.M., Resident #36 reported the potatoes were as hard as rocks and she could not eat them.</p> <p>3. Review of Resident #37's medical record revealed diagnoses of malignant neoplasm of the right breast and type two diabetes mellitus. A quarterly MDS dated [DATE] revealed Resident #37 was cognitively intact and was usually able to make herself understood.</p> <p>During an interview on 04/09/24 at 8:51 A.M., Resident #37 stated sometimes food was over and under cooked. Resident #37 stated the potatoes served for lunch on 04/08/24 were hard.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #263's medical record revealed diagnoses including type two diabetes mellitus and stage three pressure ulcer (significant wound that has penetrated through the top two layers of the skin and reached the fatty tissue beneath) of the left heel. An admission MDS dated [DATE] indicated Resident #263 was cognitively intact.</p> <p>On 04/09/24 at 8:34 A.M., Resident #263 stated he received something on his lunch tray on 04/08/24 which he assumed was supposed to be potatoes that was listed on the meal ticket but they were too hard to eat.</p> <p>47985</p> <p>5. Record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis, neoplasm of unspecified behavior of bladder, chronic obstructive pulmonary disease, atrial fibrillation, and type II diabetes.</p> <p>Review of orders revealed Resident #49 received a regular diet with regular textures and thin liquids.</p> <p>Review of a quarterly MDS completed on 02/26/24 revealed Resident #49 required set up help for eating and had no weight concerns.</p> <p>Review of a care plan completed 02/21/24 revealed Resident #49 was at risk for altered nutritional status related to weight loss, advanced age, and medical diagnoses. The goal was for Resident #49 to receive and tolerate diet as ordered and consume adequately to maintain weight with no further weight loss, maintain hydration, and aid in the maintenance of skin integrity through the next review. Interventions included encouraging Resident #49 to attend dining room for meals, provide meals and fluids based on residents food preferences and as ordered, let the resident know where food is located on the tray, and observe percentage of intakes for changes in eating habits.</p> <p>Interview on 04/08/24 at 10:10 A.M. with Resident #49 revealed he thought the food at the facility tasted terrible and was not very warm.</p> <p>Observation on 04/10/24 at 12:11 P.M. revealed State tested Nurse Aide (STNA) #122 walked out of a resident's room after delivering a tray and stated, that pizza is hard as a rock and I can't cut it. STNA #122 retrieved a grilled cheese sandwich for the resident as a substitute.</p> <p>Test tray was completed on 04/10/24 at 12:25 P.M. and revealed the pizza was burnt and black on the bottom, was hard to bite into, and did not maintain an appetizing taste.</p> <p>Interview on 04/10/24 at 2:25 P.M. with Resident #49 revealed the pizza for lunch was not good, the bottom was black and burnt, it was hard to chew and made his teeth hurt to eat.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00151791.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>47985</p> <p>Based on observation and interview, the facility failed to prepare pureed foods to meet the needs of residents requiring a pureed diet. This affected two residents (#5 and #19) of two residents who received a pureed diet. The facility census was 55.</p> <p>Findings included:</p> <p>Observation on 04/10/24 at 9:15 A.M. revealed Cook #420 washed her hands prior to beginning pureed foods. The first pureed food item to be prepared was a vegetable salad with Italian dressing. Cook #420 began by adding 12 ounces of vegetables with dressing already mixed in to the Robocoup machine. Cook #420 ran the machine for approximately 30 seconds, then paused to scrape the sides of the machine before continuing to blend again. She repeated this process 10 times. Cook #420 stated the food was not getting to the appropriate pureed texture and asked Dietary Manager (DM) #430 what to do; DM #430 stated she did not know what to do. Cook #420 stopped pureeing the mixture at 9:27 A.M. to taste, but said it was not ready to serve yet. She started to puree the mixture again for approximately 30 seconds, then stopped to scrape the sides before continuing to puree. Cook #420 stated the food was ready to serve. When tasted, chunks were still visible on tongue which was confirmed by Cook #420 and DM #430 at 9:32 A.M. Cook #420 began to puree the mixture again after adding one more serving of vegetables. After approximately 30 seconds, she paused to scrape the sides with a spatula before pureeing again. She repeated this process five times. At 9:40 A.M., Cook #420 stated the mixture was ready to serve. When tasted, the texture was still gritty with pieces getting stuck on tongue and back of mouth. Cook #420 stated she did not know what else to do to make the texture appropriate for those receiving a pureed diet. Cook #420 then added one tablespoon of Italian dressing to the mixture, pureed for approximately 30 seconds, paused to scrape the sides and added another tablespoon of Italian dressing and repeated this process three more times. Cook #420 used the back of her gloved left hand to wipe her nose, did not remove gloves or wash hands. At 9:49 A.M., she paused to taste the texture again which still had chunks of vegetables. DM #430 called Regional Dietary Manager (RDM) #160 who stated to continue running the machine. At 9:53 A.M., Cook #420 started the machine again. After approximately one minute of pureeing, Cook #420 stopped so she and DM #430 could taste the mixture, which was still gritty in consistency, and discarded their used spoons on the prep table. DM #430 picked up the spoons to throw them in the trash and Cook #420 placed her gloved right hand on the prep table where the spoons had previously been. At approximately 10:00 A.M. Cook #420 discarded the mixture and stated she would cook a different vegetable to puree.</p> <p>Interview on 04/10/24 at 10 A.M. with DM #430 confirmed above findings.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/10/24 at 10:28 A.M. revealed Cook #420 added 12 ounces of broccoli to the Robocoupe machine and began to puree. She paused to scrape the sides, added one tablespoon of Italian dressing, then started pureeing again. This process was repeated three times. RDM #160 was present at this time and instructed Cook #420 to add more liquid to the mixture; Cook #420 added a tablespoon of Italian dressing to the mixture. After approximately 30 seconds, mixture was tasted and still not a smooth consistency. Cook #420 added another tablespoon of Italian dressing and scraped sides, then continued pureeing. This process was repeated twice. At 10:40 A.M., RDM #160 took over the pureeing process and added two tablespoons of milk and one tablespoon of thickener to the mixture. At 10:49 A.M., the pureeing process was completed for the broccoli and ready to serve at the appropriate texture.</p> <p>Interview on 04/10/24 at 11:56 A.M. with RDM #160 confirmed all findings.</p> <p>The facility identified Residents #5 and #19 were to receive pureed diets.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>22653</p> <p>Based on observations, record review, review of a food preference form, and interview, the facility failed to ensure a resident received food according to assessed food preferences/dislikes. This affected one resident (#58) of 24 residents reviewed for food/nutrition.</p> <p>Findings include:</p> <p>During an interview on 04/08/24 at 11:50 A.M., Resident #58 reported she did not like the facility's scrambled eggs so the facility generally prepared and served her fried eggs.</p> <p>Review of Resident #58's medical record revealed diagnoses including morbid obesity, anxiety disorder and depressive disorder.</p> <p>A care plan initiated 03/22/24 indicated Resident #58 was at risk for altered nutritional status related to a baseline care plan indicating obesity and medication diagnoses that included hyperlipidemia, depression, vitamin D deficiency, heart failure, and stage three chronic kidney disease. Interventions included providing meals/fluids based on resident food preferences and updating/honoring resident's food preferences on the tray ticket.</p> <p>On 04/09/24 at 8:19 A.M., Resident #58 was observed in bed with her breakfast tray in front of her. Items served included scrambled eggs. Resident #58 stated she addressed it with one of the girls and was told because her meal ticket indicated scrambled eggs there was nothing she could do to provide an alternate.</p> <p>On 04/09/24 at 8:27 A.M., interview with Dietary District Manager #160 verified Resident #58's food preference list indicated she disliked scrambled eggs. Upon request, Dietary District Manager #160 stated he would prepare fried eggs for Resident #58.</p>

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<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>47985</p> <p>Based on observations, interviews, and policy review, the facility failed to store and prepare foods in a sanitary manner. This had the potential to affect all 55 residents residing in the facility.</p> <p>Findings included:</p> <p>Observations on 04/08/24 between 9:15 A.M. and 9:18 A.M. revealed an eight-quart container of rice crispies in the dry storage room with a use by date of 03/27/24, two dozen hard-boiled eggs in the walk-in refrigerator with an expiration date of 03/10/24, half a white onion with a use by date of 04/04/24, a whole onion with a use by date of 04/06/24, a half a gallon of parmesan cheese with an expiration date of 03/27/24, and a bag of shredded cheddar cheese with an expiration date of 03/27/24.</p> <p>Interview on 04/08/24 at 9:20 A.M. with Dietary Manager (DM) #430 confirmed the above findings.</p> <p>Additional observations of the kitchen on 04/08/24 at 9:26 A.M. revealed food splashes on the prep area walls, food debris and crumbs on the shelving for dishes and pans as well as on the floor below the beverage area, and sticky grime throughout the stainless-steel shelving in the kitchen. DM #430 confirmed findings at the time observations were made.</p> <p>Observation on 04/10/24 at 9:36 A.M. revealed shelving containing spices in the kitchen had a layer of dust, crumbs, and grime; the table with the steamer had a layer of sticky grime on top, the oven and stove had thick layers of grime and debris, two large white containers with flour and sugar had dark brown, sticky grime covering them, the shelf with the microwave had rust, and a container of baking soda was noted with a use by date of 01/10/24.</p> <p>Interview on 04/10/24 at 10 A.M. with DM #430 confirmed above findings.</p> <p>Observation on 04/10/24 at 10:26 A.M. revealed a white carafe on the clean dishes shelf that had dried, brown crust on it and two clear containers with food debris.</p> <p>Interview on 04/10/24 at 10:26 A.M. with Dietary Aide (DA) #410 confirmed findings, removed the white carafe and rinsed it in water before placing it back on the clean dishes shelf.</p> <p>Review of a policy titled Food Receiving and Storage (dated 01/01/22) revealed foods shall be received and stored in a manner that complied with safe food handling practices as outline in the FDA Food Code. Food Services or other staff will maintain clean food storage areas at all times, dry foods that are stored in bins and refrigerated foods stored in the refrigerator will be labeled and dated with an opened on and use by date.</p> <p>Review of a policy titled Food Preparation and Service (dated 01/01/22) revealed food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00151791.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923</p> <p>Based on record review, review of facility infection reports, review of inservice records, staff interview, and policy review, the facility failed to ensure antibiotics were not used unless criteria was met for the treatment of urinary tract infections. This affected one resident (#11) of five residents reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Review of Resident #11's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included neurogenic disorder with Lewy bodies, Parkinson's disease, psychotic disorder with delusions, anxiety disorder and chronic kidney disease.</p> <p>Review of Resident #11's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had clear speech and was usually able to make herself understood. Her cognition was moderately impaired.</p> <p>Review of Resident #11's progress notes revealed the resident was straight catheterized on 03/07/24 at 5:05 A.M. for a urinalysis. Preliminary urine results were received on 03/07/24 at 10:33 P.M. and showed the resident's urine to be straw yellow in color and its appearance was turbid. There was a large amount of leukocytes and blood in the urine, but nitrites were negative. Protein was present, white blood cells were too numerous to count and had many bacteria. The physician was notified of the results and instructed the nurse to await the urine culture results.</p> <p>Further review of Resident #11's progress notes revealed a nurse's note dated 03/08/24 at 2:38 P.M. revealed the resident had complaints of burning on urination. The physician was notified and gave an order for Pyridium (an analgesic that could relieve symptoms caused by urinary tract infections and other urinary problems) 200 milligrams (mg) by mouth x six doses. He also ordered Macrobid (an antibiotic used in the treatment of urinary tract infections) 100 mg by mouth twice a day for seven days (14 doses).</p> <p>Further review of Resident #11's progress notes revealed a nurse's note dated 03/09/24 at 12:49 P.M. that indicated the resident's urine culture and sensitivity report was received and reported to the physician. A nurse's note dated 03/10/24 at 11:07 A.M. revealed the physician gave an order to discontinue the resident's Macrobid due to the urine culture and sensitivity report that had been received. The culture and sensitivity report only showed flora.</p> <p>Review of Resident #11's physician's orders revealed resident was started on Macrobid 100 mg by mouth two times a day for 14 administrations until finished. The order had been given on 03/08/24 and was discontinued on 03/10/24.</p> <p>Review of Resident #11's urine culture report for final results resulted on 03/08/24 at 8:52 P.M. revealed the urine culture showed 50,000 CFU/ml of mixed commensal flora. The results were faxed to the physician on 03/09/24, as was hand written on the bottom of the culture report, and informed the physician the resident was currently on Macrobid. A note was added on culture report to stop the Macrobid on 03/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #11's infection report dated 03/08/24 revealed the resident had a symptom onset date of 03/06/24. Symptoms include increased frequency/ urgency and urine having a cloudy appearance. The infection report indicated a urine specimen was collected on 03/07/24. The initial urine showed positive leukocytes, white blood cells, red blood cells, bacteria, protein, and blood. The infection report indicated the culture and sensitivity report was pending and Macrobid 100 mg was ordered to be given by mouth x 14 doses. The report showed the Macrobid was discontinued due to the culture results.</p> <p>Review of Resident #11's medication administration record for March 2024 revealed the resident started receiving the Macrobid with an evening dose on 03/08/24. It was discontinued after the morning dose on 03/10/24. Findings were reviewed with the Director of Nursing (DON) on 04/10/24 at 11:50 A.M.</p> <p>On 04/10/24 at 12:05 P.M., an interview with the DON confirmed Resident #11 received an antibiotic for the treatment of a urinary tract infection that did not meet criteria for treatment. She suspected the physician started the resident on the Macrobid before the final culture results were received based on the resident's complaints of dysuria (burning with urination). She acknowledged the resident had been started on Pyridium to help with the burning with urination before the antibiotic had been started. She further acknowledged increasing fluids with the resident may have provided additional relief of her dysuria until the final culture results were available to see if she had a urinary tract infection that needed treatment. She confirmed the final culture results came back showing mixed commensal flora at 50,000 CFU/ml that did not meet criteria for treatment. She stated she had been having problems getting the resident's physician (also the facility's medical director) to abide by the antibiotic stewardship program and had educated him in the past. She stated the physician did not usually provide a rationale to them when wanting to treat a resident for an infection that did not meet criteria. He was more likely to start an antibiotic if a resident displayed symptoms of an infection or the family wanted the resident started on an antibiotic even before the final culture results were received. She acknowledged the resident received four doses of an antibiotic for symptoms of an infection that did not meet the criteria for treatment before it had been stopped.</p> <p>A review of the facility's policy on Antibiotic Stewardship Program (revised 12/13/23) revealed it was the policy of the facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program was to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The infection preventionist coordinated all antibiotic stewardship activities, maintained documentation, and served as a resource for all clinical staff. The medical director served as the primary medical point of contact for the program and served as a Liaison between the facility and other medical staff members. The antibiotic use protocols included the facility using the McGeer criteria to define infections.</p>		