STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365523	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on medical record review, observation, resident interview, staff interview, and review of the policy, the facility failed to develop comprehensive care plans which included supports for dental needs. This affected one (#1) of three residents reviewed for ancillary services. The facility census was 74. Findings Include: Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, altered mental status, chronic kidney disease, history of stroke, muscle wasting and atrophy, osteoporosis, and symbolic dysfunction. Review of Resident #1's Minimum Data Set (MDS) Annual Review dated 03/13/24 Resident #1 had no obvious or likely cavity or broken natural teeth. Review of Resident #1's most recent Quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of five indicating Resident #1 was severely cognitively impaired. Resident #1 required moderate assistance with toilet use, oral care, and dressing. Resident #1 displayed no behaviors at the time of the review. It was noted Resident #1 had no no broken or loose fitting dentures and had no mouth or facial pain, or difficulty chewing at the time of the review. Review of Resident #1's care plan revised 04/01/24 revealed supports and interventions for behaviors, self-care deficit, Alzheimer's disease, impaired cognitive function, potential for nutritional deficits, risk for impaired communication, risk for falls, and risk for pain. A care plan supports for Resident #1's broken and missing teeth and oral care needs were not found. Review of Resident #1's Dental Appointment information revealed on 03/23/23 Resident #1 was seen by the dentist and evaluated. It was documented Resident #1 had three decayed teeth, one missing tooth, and six noted root tips. It was recommended Resident #1 have six teeth extracted. It was noted at the time Resident #1 didn't want extractions, dentures, or partials. The facility was aware of the findings and Resident #1's care plan was not updated with supports or interventions for oral concerns. On 04/15/24 Resident #1 was scheduled to see the dentist and it was noted Resident #1 refused to be seen by the dentist. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/29/24 at 2:10 P.M., with Resident #1 found her to be alert and aware. Resident #1 was observed having eaten only a portion of her lunch meal and had picked her sandwich bun apart. Resident #1 reported she had a hard time eating due to her broken and missing teeth. Coinciding observation of Resident #1's teeth found a number on the right side missing, some broken, and all her remaining teeth were various shades of brown. Resident #1 reported her teeth did not hurt her, but they got in the way of her eating because she would try and chew and food would fall out of the gaps or be too large for her to swallow. Interview on 08/01/24 at 9:30 A.M., with the Administrator verified there was not a dental care plan support for Resident #1. Review of the policy titled, Comprehensive Care Plans, revised 06/30/22 revealed the comprehensive care plan would include measurable objectives and timeframes to meet a resident ' s medical, nursing, and mental and psychosocial needs, include an assessment of the resident's strengths and needs and would describe the services to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial wellbeing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Oregon		STREET ADDRESS, CITY, STATE, ZIP CODE 904 Isaac Streets Drive Oregon, OH 43616	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 AMENDED 08/27/24 Based on resident interview, medical record review, staff interview, observations, and review of policy, the facility failed to ensure residents and/or their representatives participated in resident care planning. This affected one (#129) of three residents reviewed for care plan participation. In addition, the facility failed to ensure resident care plans were reviewed and revised when a resident's smoking status changed. This affected one resident (#13) of three residents reviewed for smoking. The facility census was 74. Findings Include: 1. Review of Resident #129's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, respiratory failure, heart disease, anxiety disorder, and major depressive disorder. Review of Resident #129's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #129 was cognitively intact. Resident #129 required moderate assistance with toilet use, bathing, and dressing. Resident #126 displayed no behaviors during the review period. Review of Resident #129's care plan revised 07/24/24 revealed supports and interventions for self-care deficit, plan to discharge home with family, risk for falls, pneumonia with antibiotic use, impaired mood, risk for pain, and altered nutritional status. Review of Resident #129's medical record found no indication a care plan meeting was held with Resident #126 since his 07/11/24 readmission. Interview on 07/29/24 at 10:51 A.M., with Resident #129 revealed the resident was found to be alert and aware. Resident #129 reported he had been a prior resident at the facility but since his return earlier this month he had not participated in any type of care planning meetings. Resident #129 stated he wanted to be part of his plan development and it was important to him he had say in what he was doing while he was in the facility. Interview on 07/31/24 at 12:57 P.M., with the Administrator verified there was no care conference information regarding a meeting being held or Resident #129 participating in a care plan meeting since his 07/11/24 admission. 2. Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included cellulitis, type II diabetes, chronic obstructive pulmonary disease, mild protein calorie malnutrition, osteoarthritis, atrial fibrillation, peripheral vascular disease, major depressive disorder, and dermatitis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #13 was cognitively intact. Resident #13 was independent with eating and oral care. Resident #13 required moderate assistance with toilet use and bathing. Resident #13 required touching assistance with dressing. Resident #13 displayed no behaviors at the time of the review. Review of Resident #13's care plan revised 06/06/24 revealed supports and interventions for self-care deficit, dental problem related to dentures, discharge plan to discharge to assisted living, risk for falls, risk for impaired mood, pain, and risk for impaired skin integrity. No supports or interventions were found to be in place for smoking. Observation on 07/29/24 at 10:03 A.M., of Resident #13 found him seated in his wheelchair propelling himself into his room. Resident #13 was found to be holding a pack of cigarettes and what appeared to be a burn hole was observed on the front of his green sweater which had brown buttons down the front. Interview on 07/29/24 at 10:04 A.M., with Resident #13 verified he kept his cigarettes and did not turn them in to anyone. Resident #13 verified the holes in his sweater were burn marks from smoking but reported the holes were old. Resident #13 reported he had smoked for a long time and a few days ago the facility staff saw the burns and took his cigarettes from him but after a couple days they returned them to him. Observation on 07/29/24 at 11:28 A.M., of Resident #13 found him smoking a cigarette in the parking lot in front of the facility. Interview on 07/30/24 at 9:45 A.M., with Resident #13 revealed his cigarettes had been taken from him again this morning. Resident #13 stated he was not sure why they took them and was upset because other residents were able to keep their cigarettes and smoke. Interview on 07/30/24 at 9:51 A.M., with State tested Nursing Assistant (STNA) #463 verified Resident #13 was a smoker, had had possession of his cigarettes and they were taken from him this morning. STNA #463 reported Resident #13 was found falling asleep while he was smoking and was burning holes in his clothing so his cigarette's were removed from him. Interview on 07/30/24 at 11:17 A.M., with the Director of Nursing (DON) verified Resident #13's cigarettes were removed from him this morning. The DON reported Resident #13's care plan would be updated to including unsafe smoking and verified there had not been a smoking care plan support prior. Review of the policy titled, Comprehensive Care Plans, revised 06/30/22 revealed the comprehensive care plan would be prepared by an interdisciplinary team that included the resident and the resident's representative to the extent possible. The comprehensive care plan will describe at minimum the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing. Factors identified by the interdisciplinary team or in accordance with resident preferences will be addressed in the plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00154909.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure alternative methods of communication were provided as indicated. This affected one (#17) of one sampled residents reviewed for alternate means of communication in a facility census of 74. Findings include: 1. Review of the medical record for Resident #17 revealed admitted [DATE], with the diagnoses including: acute respiratory failure with hypoxia, cerebral infarction with left side hemiplegia and hemiparesis, chronic obstructive pulmonary disease, hypotension, seizure disorder, anxiety, depression, paranoid schizophrenia, coronary artery disease, bipolar disorder, chronic kidney disease, and benign neoplasm of heart. According to the most current minimum data set assessment dated [DATE] assessed Resident #17 with severe cognitive impairment, sometimes understands and understood, dependent on staff for the provision activities of daily living, incontinent of bowel and bladder, receives tube feeding for nutrition, and at risk for pressure ulcer development with no skin breakdown. Review of the nursing plan of care revealed the plan was revised on 05/24/24 to address Resident #17 impaired communication related to Cerebral Vascular Accident (CVA) and other symbolic dysfunction. Interventions included the following: Allow ample time for the resident to comprehend what is being communicated and allow time for response. Maintain eye contact, approach resident from the front. Observe for physical/non-verbal indicators of discomfort or distress and follow-up as needed. Pay attention to resident's body language and facial expressions. Speech Language Pathologist to screen/evaluate/treat as needed. Use simple and direct communication (i.e., yes/no questions) to promote understanding, use gestures or pictures if necessary. Observation on 07/29/24 at 9:35 A.M., noted Resident #17 making eye contact attempting to speak with air escaping through his tracheostomy stoma. Interview on 07/29/24 at 9:38 A.M., with Unit Manager Registered Nurse (RN) #513 stated resident gestures. However, no formal communication tool or technique has been established. Interview on 07/29/24 at 11:37 A.M., with Speech Language Pathologist (SLP) #414 confirmed no communication board or alternate means of communication was in the room. SLP #414 indicated the resident was evaluated previously (date undetermined) and a communication sheet was implemented for staff to utilize. SLP #414 informed the nurse on duty the day the communication sheet was placed in use. However, SLP #414 did not provide any additional staff with training on use of the communication sheet. Observation on 07/30/24 at 11:48 A.M., noted Resident #17 in bed making eye contact with verbal interaction. Interview on 07/30/24 at 11:50 A.M., with State tested Nurse Aide (STNA) #446 stated she was unaware Resident #17 had a communication sheet or was instructed on its use. STNA #446 stated resident able to communicate yes and no. Resident #17 also gestures. Observation at the time, with STNA #446 verified a communication sheet was on the resident's dresser. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbors at Oregon		STREET ADDRESS, CITY, STATE, ZIP CODE 904 Isaac Streets Drive Oregon, OH 43616	

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 07/30/24 at 2:04 P.M., with Licensed Practical Nurse (LPN) #422 Unit Manager confirmed staff were unaware to use communication sheet. Interview on 08/01/24 at 9:03 A.M., with SLP #414 indicated recommendation of the communication sheet was made approximately two years ago and she does not have documentation related to the recommendation. Observation on 08/01/24 at 9:10 A.M., noted Resident #17 dressed and groomed seated in a wheelchair outside his room. Resident #17 was gesturing nodding his head. However, the communication sheet was on his dresser inside the resident's room. Interview on 08/01/24 at 9:11 A.M., with STNA #516 stated she was unaware Resident #17 had a communication sheet and indicated he was accurate with nods his of head and related questions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 AMENDED 08/27/24 Based on observation, medical record review, resident interview, staff interview, and review of policy, the facility failed to ensure residents who required staff assistance with activities of daily living, received adequate and timely care to maintain good personal hygiene including nail care, bathing, and shaving. This affected four (#15, #16, #19, and #185) of seven residents reviewed for activities of daily living. The facility census was 74. Findings Include: 1. Review of Resident #16's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes, chronic obstructive pulmonary disease, dementia, anxiety disorder, and anoxic brain damage. Review of Resident #16's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero indicating Resident #16 was severely cognitively impaired. Resident #16 was dependent on staff for all activities of daily living. Review of Resident #16's care plan revised 07/18/24 revealed supports and interventions for self-care deficit. Interventions included one person assist for bathing and two person assist with personal hygiene. Observation on 07/29/24 at 3:05 P.M., of Resident #16 found Resident #16 was not able to be interviewed. Resident #16's fingernails were long and had a brown substance under his nails. Resident #16 had dried food on his shirt and his hair was oily and uncombed. Interview on 07/30/24 at 9:52 A.M., with State tested Nursing Assistant (STNA) #446 revealed Resident #16 was totally dependent on staff for all care needs including bathing and nail care. Coinciding observation of Resident #16 found his hair was unwashed and his finger nails were long and had a brown substance under his nails. STNA #446 verified Resident #16's nails were long and unclean. STNA #446 stated many of the staff were afraid of Resident #16 due to his behaviors and often did not provide nail care or showers. STNA #446 reported Resident #16 was to receive a shower on night shift and Resident #16 had not been showered in a long time. STNA #446 reported she provided bed baths daily but verified Resident #16 was not showered twice a week as he was supposed to. Review of the policy titled, Activities of Daily Living, revised 01/01/22, revealed a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the policy titled, Bathing a Resident, revised 10/01/23, revealed it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. 15816 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record of Resident #15 revealed an admitted [DATE], with the diagnoses including: urinary tract infection, chronic obstructive pulmonary disease, seizure disorder, diabetes mellitus, adjustment disorder with depressed mood, hypertension, bipolar disorder, bladder disorder, chronic pain syndrome, heart failure, and muscle weakness. According to the most current minimum data set assessment dated [DATE] assessed Resident #15 with intact cognition, no refusal of care, dependent on staff for the completion of activities of daily living (ADL), incontinent of bowel and bladder, at risk for pressure ulcer with a diabetic foot ulcer. Interview on 07/29/24 at 11:12 A.M., with Resident #15 revealed she had not received a shower since 05/13/24. The resident stated she had received a couple bed baths since that time. However, no showers. The resident indicated she did not feel clean. The residents hair appeared greasy and matted. Review of the plan of care revised 03/15/24, developed to address Resident #15 ADL self-care performance deficit related to diabetes, chronic obstructive pulmonary disease, hypertension, muscle wasting , bladder spasms, Insomnia and chronic pain. Interventions included; One person assist with bathing. Two person assist with personal hygiene. Transfer with two person assistance and use mechanical lift. Review of physician order date 05/23/24 revealed a physician order was implemented for Resident #15 scheduled bathing days, every Monday and Thursday during the evening shift. Review of shower documentation from June and July 2024 noted Resident #15 to be scheduled for showers twice weekly on Monday and Thursday during second shift. According to shower completion documentation Resident #15 was hospitalized between 06/09/24 and 06/11/24. During the month of June 2024 Resident #15 had five opportunities for scheduled showers. Of the five opportunities Resident #15 received showers two times on 06/13/24 and 06/20/24. Review of July 2024 shower documentation noted Resident #15 hospitalized between 07/07/24 and 07/08/24. Showers were documented as completed two of eight opportunities on 07/04/24 at 4:51 A.M. and 07/05/24 at 1:50 P.M. Interview on 07/30/24 at 3:05 P.M., with Licensed Practical Nurse (LPN) #482 Unit Manager during review of shower documentation confirmed missed showers on the described dates. Review of the policy titled, Activities of Daily Living, revised 01/01/22, revealed a resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the policy titled, Bathing a Resident, revised 10/01/23, revealed it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. 45445 3. Review of the medical record for Resident #19 revealed an admitted [DATE], diagnoses included chronic respiratory failure, nontraumatic intracerebral hemorrhage, type 2 diabetes mellitus, depression, anxiety disorder, dysphagia, hypertension, encephalopathy, and bipolar disorder. Resident #19 had a tracheostomy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual MDS assessment dated [DATE] revealed Resident #19 had no speech, rarely never is understood and sometimes understands others. Resident #19's cognitive status was unable to be assessed due to a memory problem. Resident #19 had functional impairments to both upper and lower extremities, utilized a wheelchair for mobility and was dependent for mobility, as well Resident #19 was dependent for activities of daily living, and transfers, was always incontinent of bowel and bladder. Review of the care plan dated 09/06/23 revealed Resident #19 had an activities of daily living self-care performance deficit related to contracture's and encephalopathy. Interventions included bathing with the assistance of one person, bed mobility and incontinence care completed with the assistance of two people, and all transfers were completed with a mechanical lift with two staff assistance. Resident #19 had also been cared planned on 02/08/24 for impaired muscle skeletal status related to muscle wasting and atrophy. Interventions included to administer medications as ordered, observe for fatigue, provide assistance with turning and repositioning as resident will allow, allow ample time to reduce pain, and physical therapy, occupational therapy and speech therapy evaluation and treatment as needed. Review of the current physician orders for Resident #19 revealed bed baths are provided on first shift every Wednesday, Friday and Sunday. Review of the Treatment Administration Record (TAR) for July revealed a bed bath was provided on Sunday, 07/28/24, on Friday, 07/26/24 and on Wednesday, 07/24/24. Observation of Resident #19 on 07/29/24 at 5:03 P.M., revealed Resident #19 sat up right on bed, with head of bed elevated at approximately thirty degrees with hands clinched and white stubble about a quarter inch long on Resident #19's chin. An additional observation on 07/30/24 at 2:26 P.M., of Resident #19 sitting upright in reclining wheelchair in dining room with residents playing in bingo revealed white colored whiskers along Resident #19's chin line. Interview on 07/30/24 at 2:30 P.M., with STNA #477 verified Resident #19 had white colored whickers along chin line. STNA #477 stated Resident #19 is to be shaved when the resident is bathed or showered. 4. Review of the medical record for Resident #185 revealed an admitted [DATE], with a readmission on 07/13/24 diagnoses included acute respiratory failure with dependence on a respirator, chronic obstructive pulmonary disease, chronic kidney disease, congestive heart failure, peripheral vascular disease, anxiety disorder, dysphagia, iron deficiency anemia, hypertension, major depressive disorder, and right and left carotid stenosis. Review of the annual MDS assessment dated [DATE] revealed Resident #185 was cognitively intact, had clear speech, was understood, had no functional impairment and was independent with activities of daily living and mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS assessment dated [DATE] revealed Resident #185 was cognitively intact, had no speech, related to a tracheostomy and was ventilator dependent, was understood, had no functional impairment and was dependent on toilet hygiene, bathing, showering and personal hygiene and required maximal assistance for dressing. Review of the care plan dated 07/13/24 for Resident #185 revealed an activities of daily living self-care deficit with a goal to have activities of daily living needs met. Interventions included one assist with toilet hygiene, bathing and personal care. Review of the current physician orders revealed bathing days every Monday and Friday on evening shift. Review of the treatment administration record for July 2024 revealed no bathing occurred on 07/19/24, 07/22/24, and 07/29/24. Interview with Resident #185 on 07/29/24 at 12:13 P.M., revealed Resident #185 is not receiving showers or bathing assistance on a regular basis. Resident #185 stated I need a bath and assistance with shaving. Resident #185 shared that his brother had bought and brought in an electric razor, further stating, no one has helped with shaving even upon asking. Observation, at the time of the interview, revealed grayish-white stubble on face, prefers not to have a beard. Have razor that brother brought in, and no one has used. Additional interview on 07/30/24 at 11:00 A.M., with Resident #185 verified no bathing assistance was provided on 07/29/24. Interview on 07/31/24 at 7:48 A.M. with STNA #520 verbalized knowledge of Resident #185 not getting showers since returning from the hospital on 07/13/24. STNA #520 stated Resident #185 is to receive bed baths on the evening shift on Mondays and Fridays. STNA #520 denied no knowledge of bathing assistance not being provided. Review of the bathing documentation with STNA #520 verified no bed bath had been completed on 07/19/24, 07/22/24 and 07/29/24. STNA #520 also verified the grayish white colored stubble on Resident #185's face and further verified the resident likes to be cleaned shaved. Review of the policy titled, Activities of Daily Living, revised 01/01/22, revealed a resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the policy titled, Bathing a Resident, revised 10/01/23, revealed it was the practice of the facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on record review, observation, staff interview and review of the clinical protocol, the facility failed to identify, report and timely assess an alteration in skin integrity. This affected one (#19) of six resident reviewed for skin integrity. The facility census was 74. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE], diagnoses included: chronic respiratory failure, nontraumatic intracerebral hemorrhage, type 2 diabetes mellitus, depression, anxiety disorder, dysphagia, hypertension, encephalopathy, and bipolar disorder. Resident #19 had a tracheostomy. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had no speech, rarely never is understood and sometimes understands others. Resident #19's cognitive status was unable to be assessed due to a memory problem. Resident #19 had functional impairments to both upper and lower extremities, utilized a wheelchair for mobility and was dependent for mobility, as well Resident #19 was dependent for activities of daily living, and transfers, was always incontinent of bowel and bladder. Had no skin impairments however was at risk for skin breakdown with pressure reducing devices to wheelchair and bed. Review of the care plan dated 09/06/23 revealed Resident #19 was a risk for alterations of skin, interventions included to turn and reposition frequently, air mattress to bed, pressure relieving device to wheelchair, pressure boots to bilateral feet at all times, weekly skin checks and to report any redness or skin alterations noted with daily care and bathing. Review of the current physician orders for Resident #19 revealed an order written on 06/29/23 for weekly skin assessments every Thursday on day shift, orders written on 06/30/24 for pressure relieving boots on both feet at all times, with skin integrity to be checked daily on the day shift to ensure no irritation or redness. Review of the skin assessments completed on 04/18/24, 05/23/24, 06/20/24 and 07/25/24 revealed no abnormal skin areas. Review of the point of care documentation for July 2024 revealed no abnormal skin area. Review of the podiatry note dated 05/28/24 revealed Resident #19 was seen for at risk foot care, has peroneal muscle atrophy, had experience relief after the last visit, but symptoms have returned. Resident #19 had elongated, thickened, brittle and discolored toenails, hyperkeratosis on the plantar aspect right second toe which was debrided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of personal care completed on 07/30/24 at 3:13 P.M., provided by State tested Nursing Assistant (STNA) #428 and #477 revealed two darken scabbed areas on Resident #19's left foot. The first area on the tip of left great toe, was round and measured approximately 0.1 centimeter (cm) long by 0.1 cm wide, the second area was on the lateral side of the contracted fourth toe. The darkened area ran the length of the side of the contracted toe with dry peeling white skin surrounding the darkened area surrounded by redness. Additional observation on 07/31/24 at 7:30 A.M., of Resident #19 revealed blue pressure relieving boots in place to bilateral lower extremities. Dark crusty area remains to the tip of the left great toe and the lateral side of the contracted left fourth toe. The skin to both feet was dry and cracked. Observation on 07/31/24 at 12:30 P.M., with the Director of Nursing (DON) verified a pinpoint dark area to the left great toe, approximately 1.0 centimeter (cm) round and an area on the left forth toe is approximately 0.3 cm long by 0.1 cm wide with dry peeling skin surrounding. The DON, pointing to the lateral side of the fourth toe, stated, I would love to pick that off and see what underneath. Further review of the medical record for Resident #19 revealed a Podiatry note dated 07/31/24 revealed small eschar's to the right foot with no drainage or redness. Review of the skin wound evaluation note dated 07/31/24 and timed 3:19 P.M., revealed Resident #19 had a new in house acquired diabetic foot ulcer to the right great toe, measurements were 1.3 cm long by 0.8 cm wide by 0.1 cm deep. Review of a nurse progress note dated 07/31/24 and timed 3:50 P.M., revealed Resident #19 had dry skin on and under all left toes, toes cleansed, moisturizer applied, and dry skin came off with a small wound noted on the left great toe. Per physician, the wound was labeled a diabetic ulcer. Povidone iodine applied. Additional review of the physician orders revealed an order written on 07/31/24 at 4:36 P.M. for the left great toe diabetic ulcer to be monitored daily and left open to air. Interview on 08/01/24 at 7:33 A.M., with the Assistant Director of Nursing (ADON) #510 verified Resident #19 did have dry skin on and under all left toes, the toes were cleansed, moisturizer applied, and dry skin came off. ADON #510 stated Resident #19 had a small wound noted to left great toe and per the physician the wound was labeled as a diabetic foot ulcer. Review of the clinical protocol titled Pressure Ulcer/Skin Breakdown, dated 01/01/22 stated at risk residents needs are to be identified to ensure prompt interventions are implemented when skin issues are identified. Continued weekly skin assessments and evaluations are completed by licensed nurses on residents with no identified skin concerns and by certified aides with point of care documentation when providing care and bathing. This deficiency represents non-compliance investigated under Complaint Number OH00156481 and Complaint Number OH00156247.

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	365523	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on resident interview, medical record review, and staff interview, the facility failed to ensure audiology services were provided timely for residents with identified hearing concerns. This affected one resident (#70) of two residents reviewed for audiology services. The facility census was 74. Findings Include: Review of Resident #70's medical record revealed an admitted [DATE]. Diagnoses included conductive hearing loss, impacted earwax, and injury of thorax subsequent encounter. Review of Resident #70's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #70 was cognitively intact. Resident #70 required touching assistance with toilet use, bathing, and parts of dressing. Resident #70 was highly hearing impaired and did not have hearing aides at the time of the review. Resident #70 displayed no behaviors at the time of the review. Review of Resident #70's care plan revised 05/16/24 revealed supports and interventions for self-care deficit, risk for falls, risk for pain, and impaired communication related to hearing loss. Interventions included allowing ample time for resident to comprehend what was being communicated and allow time for response, anticipate and meet needs, and audiology referral as needed. Review of Resident #70's Authorization Form for Ancillary and Medical Services dated 04/24/24 revealed Resident #70 authorized audiology services to be provided. Review of Resident #70's Audiology notation revealed on 07/25/24 Social Services contacted the audiologist regarding connecting Resident #70 for an evaluation. No appointment had been scheduled. Interview on 07/29/24 at 1:20 P.M., with State tested Nursing Assistant (STNA) #463 revealed Resident #70 was not able to hear. They communicate with him by writing things down. Resident #70 was able to understand and speak clearly, he just was not able to hear. STNA #463 was not sure why. Interview on 07/29/24 at 1:23 P.M., with Resident #70 found him to be alert and aware, but unable to hear. All questioned were typed. Resident #70 was able to respond verbally after reading the questions. Resident #70 reported he needed to have his ears cleaned and needed to see the audiologist. Resident #70 reported he had not been seen by anyone since he came here and it had been a while before that when his ears were last taken care of. Resident #70 showed a tissue with significant amounts of what appeared to be ear wax in it. Resident #70 stated he needed to have his eardrums repaired when he was young and ever since then his ears needed to be drained and unplugged at least every six months. Resident #70 reported hearing aides do not do any good because of the large build up of wax. Resident #70 stated the wax needed to be removed by a doctor. He said he tried to get some out himself but he wasn't able to get enough to make a difference. He told the staff here when he came in and they know he can't hear but he had not seen anyone yet and was not sure when his ear cleaning would get done. (continued on next page)

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	365523	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/30/24 at 3:08 P.M., with Social Services Director (SSD) #485 verified the first contact she was aware of with audiology for Resident #70 was not made until 07/25/24, approximately three months since his admission. SSD #485 reported she was not aware Resident #70 had ear concerns. SSD #485 reported she would talk with Resident #70 as he may need to go out for audiology care depending on if his needs could be provided for during the in house visits or not. This deficiency represents non-compliance investigated under Complaint Number OH00155767.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 AMENDED 08/27/24 Based on observation, medical record review, family and staff interview, and review of the facility's Pressure Ulcer/Skin Breakdown Clinical Protocol, and review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to accurately assess wounds, provide timely interventions to prevent the development of pressure ulcers or healing of existing pressure ulcers, failed to obtain timely treatments of existing wounds, and failed to timely identify the resident's pressure ulcers until it reached an advanced stage. This resulted in Actual Harm to Residents #79 and #40 who were at risk for pressure ulcers and the facility found Resident #79's pressure ulcer as an unstageable pressure ulcer (Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar) and Resident #40's pressure ulcer as a stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed). Actual Harm occurred to Resident #184 when the resident was admitted with two unstageable pressure ulcers, and a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue) and did not have any treatments in place while residing in the facility for six days. Resident #184 was sent to the emergency roiagnom on the sixth day due to decubitus pressure injury of the sacral region, sepsis and respiratory failure. This affected three (#40, #79, and #184) of six residents reviewed with pressure ulcers. The facility census was 74. Findings include: 1. Closed medical record review revealed Resident #79 was admitted to the facility on [DATE] with the diagnoses included cerebral infarction, cerebral aneurysm, type II diabetes mellitus, coronary artery disease, congestive heart failure, anemia, osteoarthritis, seizure disorder, dysphagia, chronic inflammatory disease of uterus, and anxiety disorder. Review of the physician order dated 01/26/23 revealed an order for the application of protective cream to buttocks each shift and as needed (PRN). On 03/02/23, an order for a frozen nutritional treat (or equivalent) (high calorie) one time a day with dinner related to weakness. Review of the nursing care plan dated 08/21/23 revealed Resident #79 was at risk for impaired skin integrity related to cerebral vascular accident with left sided weakness, diabetes, coronary artery disease, congestive heart failure, osteoarthritis, and weakness. Interventions were implemented on the following dates: on 08/21/23, an air mattress with bed bolsters to establish safe parameters, apply protective barrier cream after incontinent episodes, assist the resident with turning and repositioning as needed, encourage the resident to reposition self if able, notify nurse of any new areas of skin impairment noted during bathing or daily care (e. g. redness, blisters, bruises, discoloration), notify Physician/Physician Assistant/Nurse Practitioner of any new areas of skin impairment, preventive treatments per orders, complete skin inspection weekly and as needed, consult dietitian as needed, dietary supplements as ordered, encourage good nutrition and hydration. Assist as needed. Provide a non-irritating surface to reduce friction or shearing forces. Provide incontinence care as needed. On 08/29/23, a pressure redistribution device was placed in chair. On 03/19/24, monitor dressings each shift and change as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the medical record revealed it lacked documentation indicating an air mattress with bed bolsters was applied to the bed, pressure redistribution device was placed to the chair, or turning and repositioning was provided consistently. Review of the skin risk assessment dated [DATE] revealed Resident #79 was at moderate risk for pressure ulcer development. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 was assessed with moderate cognitive impairment and had no behaviors of refusal of care during the review period. Resident #79 was dependent on staff for the completion of activities of daily living, which included with bed mobility and transfers. Resident #79 utilized a wheelchair for mobility. Resident #79 was incontinent of bowel and bladder, had no reports of pain during the assessment period, no weight loss, received a mechanically altered and therapeutic diet, at risk for pressure ulcer development with no skin breakdown identified. Review of the Task Documentation Survey Report for tracking turning and repositioning per the care plan revealed it lacked documentation during May 2024 of every two hour turn and repositioning. The documentation noted repositioning was provided on 05/06/24 at 12:16 A.M., 05/11/24 and 05/19/24 between 12:00 A.M. and 6:00 A.M., 05/25/24 between 12:00 A.M. and 2:00 A.M. No further repositioning was documented between 12:00 A.M. and 6:00 A.M. during May 2024. Additional review of two hour turns and repositioning documentation revealed on 05/27/24 between 9:24 P.M. and 05/28/24 at 2:00 P.M., and 05/28/24 between 9:24 P.M. and 05/29/24 at 2:00 P.M., no repositioning was recorded in the medical record. The medical record lacked consistent documentation recording turning and repositioning every two hours through 06/18/24. Review of the skin assessment dated [DATE] at 5:21 P.M. revealed an abnormal skin area was identified to the sacrum. The area was described as moisture associated skin damage (MASD). No measurement or evaluation of the impaired skin was documented. No further assessment was contained in the medical record regarding the sacral MASD. On 05/29/24 at 2:25 P.M., a physician order was obtained by Licensed Practical Nurse (LPN) #455 for a treatment to Resident #79's coccyx. The order included to flush wound with normal saline, pack with Iodoform, cover with foam dressing everyday shift for open area. Review of the Incident Description New Pressure Ulcer documentation revealed on 05/29/24 at 5:15 P.M., LPN #455 was notified by care staff Resident #79 was discovered with an open area to coccyx. Resident stated her buttocks hurt. LPN #455 documented unaware Resident #79 had an open area. A treatment was applied to the area. The nursing note dated 05/29/24 at 5:19 P.M., revealed LPN #455 documented during care a staff member noticed open area to resident's coccyx and reported to nurse whom further evaluated. The skin assessment dated [DATE] at 5:26 P.M. revealed a pressure area to the coccyx. No documentation indicated wound measurements were obtained or an evaluation of the area was noted. The medical record was silent to wound measurements, descriptions, or additional interventions being implemented on 05/29/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The initial wound description was completed on 05/30/24 and identified a right gluteal wound was evaluated as in-house acquired with origin date of 05/29/24. The wound descriptions noted it was an unstageable pressure ulcer to the right gluteal with 100% slough and moderate amount of serosanguineous (blood tinged) exudates (drainage). Measurements were noted 0.67 centimeters (cm) length by (x) 0.96 cm width x 0.2 cm depth, undermining was recorded 0.5 cm from 12 to 12 o'clock. The right gluteal dressing treatment was changed by the physician on 05/30/24 to include Santyl External Ointment (debriding agent) 250 unit/gram (gm) (Collagenase). Apply to right gluteus topically as needed for wound care, cleanse wound with in-house wound cleanser, pat dry, apply nickel thick layer of Santyl to wound bed, lightly pack with saline moisten gauze, and cover with dry dressing. The physician orders dated 05/30/24 included the application of an air mattress with bed bolsters to the bed and monitor dressing(s) every shift to ensure they were clean, dry, and intact. If not, replace dressing to be completed every day and night shift. On 06/06/24, the wound measurements and descriptions contained in the medical record noted the right gluteal wound measured 3.19 cm long x 2.43 cm wide x 0.2 cm deep. The wound bed was assessed with 20% granulation, 60% slough, 20% eschar, and moderate amount of serosanguineous drainage. The physician was notified on 06/06/24 and modified the order to the wound to include the application of Santyl External Ointment 250 unit/gm (Collagenase) to apply to right gluteus topically as needed for wound care, cleanse wound with in-house wound cleanser, pat dry, apply nickel thick layer of Santyl to wound bed, lightly pack with Dankin's moisten gauze, and cover with dry dressing every day shift for wound care. On 06/13/24, the right gluteal wound was documented with measurements 3.92 cm long x 5.48 cm wide x 0. 5 cm deep and undermining of 0.3 cm from five to nine o'clock. Wound bed was described with 20% granulation, 40% slough, 40% eschar, and moderate amount of serosanguineous drainage. On 06/14/24, the physician ordered Santyl External Ointment 250 unit/gm (Collagenase) to apply to right gluteus topically as needed for wound care, cleanse wound with in-house wound cleanser, pat dry, apply nickel thick layer of Santyl to wound bed, lightly pack with calcium alginate, and cover with dry dressing. On 06/17/24, the physician ordered a referral to wound care for an unstageable pressure ulcer to the right gluteus. However, Resident #79 was not evaluated by the wound care specialist and was discharged to the hospital on 06/19/24. Resident #79 did not return to the facility. Interview on 07/31/24 at 7:55 A.M. with LPN #455 confirmed on 05/29/24, she was notified by care staff that Resident #79 had an area of skin breakdown to the right gluteal. LPN #455 was not informed the resident had an open area prior to assuming care of the resident. LPN #455 observed the wound and stated was open and draining. LPN #455 indicated she was unaware why the wound was not discovered before it was found to be open and draining blood-tinged exudates. LPN #455 verified Resident #79 was dependent on staff for repositioning and had a standard pressure relief mattress in place without an air mattress. The physician and family were notified, and a treatment was implemented. LPN #455 verified she did not obtain wound measurements, document wound description, or implement any additional interventions on 05/29/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/31/24 at 8:06 A.M. with Unit Manager (UM) #422 revealed she was informed via incident report completed 05/29/24 that Resident #79 was discovered with a pressure ulcer to the right gluteus. On 05/29/24, LPN #455 completed an incident report with notifications of physician and family. UM #422 verified she initially assessed Resident #79's wound on 05/30/24 and obtained a photo. UM #422 indicated the wound was open and draining blood-tinged exudates. The wound photo was provided to the Director of Nursing (DON) and measurements with descriptions were obtained using the photo. UM #422 further stated Resident #79 had been declining with nutritional intake and was unable to reposition herself. UM #422 verified prior to 05/30/24, Resident #79 was on a standard mattress and not an air mattress as listed in the plan of care. UM #422 confirmed no measurements or wound description was obtained until 05/30/24 and confirmed there was no documentation indicating Resident #79 was repositioned in accordance with a repositioning program every two hours. Interview on 07/31/24 at 8:31 A.M. with the DON verified there were no measurements or description of Resident #79's wound obtained until 05/30/24, no evidence of an air mattress was in place until 05/30/24, and there was no consistent documentation of turning and repositioning during the third shift between 12:00 A.M. and 6:00 A.M. in the months of May and June 2024. The DON verified there was no investigation completed including staff interviews into the origin of the wound before it was discovered open and draining blood-tinged exudates. The DON also confirmed the wound was not staged while the resident resided at the facility due to the amount of slough contained inside the wound. Additional interview on 08/01/24 at 9:42 AM with the DON stated UM #522 observed Resident #79's wound and obtained a photo. The DON stated she reviewed pictures of the wound and utilized the pictures to determine the wound description. The DON further confirmed she did not physically observe the wound to determine a description and measurements. The wound was unable to be staged due to the amount of slough tissue inside the wound. 45445 2. Review of the medical record for Resident #40 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, peripheral vascular disease, tracheostomy, dependence on respirator, atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively impaired, was dependent on staff for activities of daily living and mobility, had an indwelling urinary catheter, was always incontinent of bowel, and was risk for pressure ulcer with no unhealed pressure ulcer present. Review of the care plan initiated on 09/06/23 revealed Resident #40 was at risk for impaired skin integrity related to respiratory failure, seizures, encephalopathy, peripheral vascular disease, atrial fibrillation, neurogenic bladder, anemia, vegetative state, and hypertension. Interventions included the administration of medications as ordered, the application of protective barrier with each incontinence episode, assistance with turning and reposition as needed, completing a Braden scale as needed, providing dietary supplements as ordered, elevation of heels off the mattress as tolerated, and to notify the nurse of any new skin areas of skin impairment during bathing or daily care, as well as notification to the provider of any new skin impairment. Resident #40 was also to have a pressure redistribution device to chair, specialty air mattress to bed with bilateral bolster, preventive treatments provided as ordered, and incontinence care as needed. The care plan was revised on 07/31/24 to reflect a stage III pressure ulcer to the coccyx with interventions to include monitoring the dressing every shift and change as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the weekly skin assessments revealed Resident #40 had a pressure ulcer to the coccyx which was resolved on 04/17/24. From 04/17/24 to 07/15/24, Resident #40 had no abnormal skin areas. Resident #40 was sent out to the hospital for evaluation of shortness of breath on 07/16/24 and returned to the facility on [DATE]. Review of the hospital record revealed a wound care consult dated 07/18/24 for moisture associated skin damage (MASD) to the sacrum on 07/18/24. The wound care noted a sacral wound, history of a stage IV pressure ulcer in 2022. The wound assessment revealed a denudation to the buttocks and a linear area of erosion in gluteal cleft. Hospital staff did apply fecal pouch, as patient was having multiple loose stools overnight. A protective foam dressing in place over the gluteal cleft at time assessment, which was trapping a lot of moisture in gluteal cleft. Wound care recommendation was for triad cream twice a day and when incontinent after the area was cleansed with soap and water and patted dry. Additionally, Resident #40 was to be turned and repositioned every two hours while in bed, heels floated off the bed with pillows under calves, and a single layer moisture wicking under pad under the resident. Review of the continuation of care paperwork printed 07/20/24 at 10:11 A.M. revealed Resident #40's buttocks were to be cleaned with soap and water, patted dry, followed by the application of triad cream twice a day and as needed when incontinent. There was no physician order at the facility implemented for this skin treatment to continue as the hospital recommended. Review of the nursing readmission evaluation dated 07/20/24 and timed 3:27 P.M. Resident #40 was noted to have MASD of the coccyx. There was no mention of an open area to the coccyx. There were no weekly skin assessments completed from 07/21/24 to 07/30/24. There were no physician orders for a foam dressing to be in place until 07/31/24. There was no treatment for a foam dressing noted in the treatment administration record. Interview with Resident #40's family member on 07/30/24 at 3:15 P.M. revealed concerns related to the timeliness of care including suctioning, repositioning and incontinence care. The family member stated there was now a camera in the resident's room and if family member notices more than two and half hours have gone by without Resident #40 being checked, changed and repositioned, she called the facility to get someone into the room to provide the care. The family member verbalized concern over Resident #40's skin due to a pressure ulcer Resident #40 on the coccyx that took over two years to heal. There was no mention of an open area to Resident #40's coccyx until 07/31/24. Observation of incontinence care on 07/31/24 at 7:30 A.M. for Resident #40 completed by State tested Nursing Assistant (STNA) #423 and #463 revealed Resident #40 had a foam dressing on the coccyx dated 07/31/24 and timed 2:40 A.M., the foam dressing was loose and soiled with stool. STNA #463 removed the foam dressing and alerted the nurse of the dressing needing to be replaced. Observation of Resident #40's skin when the dressing was removed revealed an open reddened area of skin approximately 2.0 cm long by 2.0 cm wide in the upper gluteal cleft. Skin care was completed with soap and water, and the area was patted dry. Registered Nurse (RN) #515 entered the room at 7:40 A.M. and placed a new clean foam dressing over the open area on the coccyx. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/31/24 at 7:45 A.M. with RN #515 verified Resident #40 had an open area and further verified the foam dressing was in place to protect to the area. Interview on 07/31/24 at 12:30 P.M. with the Director of Nursing (DON) revealed no knowledge of Resident #40 having an open area to the coccyx. Review of the skin and wound evaluation dated 07/31/24 at 3:14 P.M. revealed Resident #40 had a stage three pressure ulcer to the coccyx, measuring 1.9 centimeters (cm) long by 0.9 cm side by 0.1 cm deep with 100 percent of wound filled. The physician was notified, and an order was received on 07/31/24 to cleanse the coccyx with in-house wound cleaner, pat dry, apply collagen and cover with foam dressing every day and as needed. Review of the nursing progress note revealed a note dated 07/31/24 at 3:31 P.M. revealed a small open area on coccyx, area cleansed with soap and water and a foam dressing applied. Interview on 08/01/24 at 7:33 A.M. with the Assistant Director of Nursing (ADON) #510 verified Resident #40 had a stage III pressure ulcer to the coccyx, the physician was notified with treatment orders obtained and family was updated. ADON #510 verified the medical record for Resident #40 contained no evidence of the open area to the coccyx of Resident #40 prior to 07/31/24. 3. Review of the medical record for Resident #184 revealed an admitted [DATE]. Diagnoses included acute respiratory failure, chronic obstructive pulmonary disease, type II diabetes mellitus, end stage renal disease, dependence on dialysis, major depressive disorder, tracheostomy, and atrial fibrillation. Review of the continuation of care paperwork dated 07/24/24 revealed Resident #184 had a traumatic injury wound to the left anterior foot with a measurement of 1.2 centimeters (cm) long by 4.5 cm wide, an unstageable pressure ulcer to the left proximal dorsal thigh with a measurement of 3.1 cm long by 6.6 cm wide by 0.2 cm deep, an unstageable pressure ulcer to the sacrum, measurements 7.1 cm long by 6.9 cm wide by 0.1 cm deep, and a deep tissue injury (DTI) to the right heel with measurements of 2.5 cm long by 2. 5 cm wide. Resident #184 was also noted to have redness to the left cheek and dry skin to the left abdomen. Review of the nursing admission evaluation completed on 07/25/24 at 12:11 A.M. revealed Resident #184 did not have any identified skin conditions. Review of the physician orders dated 07/25/24 revealed an order for protective cream to buttocks after episode of incontinence and to complete weekly skin assessments. There were no treatments in place to the unstageable pressure ulcers on the left proximal dorsal thigh and sacrum, or DTI to the right heel. Review of the care plan dated 07/25/24 revealed Resident #184 was identified at risk for impaired skin integrity. Interventions included to administer medications as ordered, apply protective barrier cream after incontinence episodes, completed Braden scale as needed, dietary supplements as ordered, pressure/redistribution mattress to bed/chair, report any new areas of skin impairment noted during bathing or daily care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Oregon		STREET ADDRESS, CITY, STATE, ZIP CODE 904 Isaac Streets Drive Oregon, OH 43616	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Braden scale for predicting pressure sore risk completed on 07/25/24 at 12:10 A.M. revealed Resident #184 was at moderate risk for developing pressure ulcers. Resident #184 was identified as being unresponsive, with usually dry skin, was confined to bed with very limited mobility, had adequate nutrition and had no apparent problem with friction or shear as the resident moves in the bed and chair independently. Review of the physician history and physical completed on 07/25/24 revealed there was not a skin assessment completed for Resident #184. Review of the skilled nursing assessment completed on 07/26/24 at 12:23 P.M., on 07/28/24 at 12:46 A.M. and 3:13 P.M. revealed Resident #184 had no abnormal skin conditions. The skilled nursing assessment completed on 07/30/24 at 12:11 A.M. revealed Resident #184 had abnormal skin conditions. Review of the pulmonary nurse practitioner note dated 07/26/24 revealed Resident #184 had multiple wounds covered with dressings. Review of the nutritional note dated 07/29/24 and timed 8:18 A.M. revealed Resident #184 had intact skin. Review of the nursing progress notes revealed a note dated 07/30/24 at 7:10 P.M. revealed the day shift nurse reported Resident #184 had a necrotic area to the coccyx with Resident #184 requiring total care and repositioned on the right side. A progress note dated 07/30/24 at 9:00 P.M. stated Resident #184 was transported to the hospital with family updates provided. Observation on 07/30/24 at 4:30 P.M. revealed staff moving quickly into Resident #184's room, followed by the door being closed. Interview on 07/30/24 at 4:45 P.M. with Licensed Practical Nurse (LPN) #650 revealed Resident #184 had a wound to the coccyx that appeared to be necrotic. LPN #650 believes in contributing to a change in condition for Resident #184 as Resident #184 had been clammy all day. LPN #650 stated Resident #184 was going to be sent out to the hospital for evaluation. Interview on 07/30/24 at 5:15 P.M. with State tested Nursing Assistant (STNA) #503 at the bedside of Resident #184 verified Resident #184 had a necrotic area to the coccyx and after cleaning Resident #184 the resident was repositioned off his back. STNA #503 added she was remaining with Resident #184 until the nurse returned. Review of the Emergency Department record dated 07/30/24 revealed Resident #184 was sent to the emergency department for an evaluation of wounds with facility concerns about a decubitus ulcer on Resident #184's buttocks and developing wounds on the lower legs. Review of Resident #184's emergency department assessment revealed a wound of the left foot measured 0.5 cm long by 1.5 cm wide that goes down to the subcutaneous fascia, a coccyx wound, a right heel wound, and wounds to the left upper chest and face. left dorsal foot, right lateral calf, and right arm. Resident #184 was admitted to the hospital on 07/31/24 at 2:10 A.M. with a decubitus pressure injury of the sacral region, sepsis and respiratory failure. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbors at Oregon		STREET ADDRESS, CITY, STATE, ZIP CODE 904 Isaac Streets Drive Oregon, OH 43616	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/05/24 at 3:30 P.M. with the Director of Nursing denied knowledge of Resident #184 having any wounds and further verified the medical record for Resident #184 was silent for wound treatment orders and the care and treatment of any wounds since Resident #184's admission on 07/24/24. Review of the facility's Pressure Ulcer/Skin Breakdown Clinical Protocol last revised 01/01/22 revealed because a resident at risk can develop a pressure ulcers/pressure injuries (PU/PI) within hours of onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent PU/PI. The interdisciplinary team will assess and document and individual's significant risk factors for developing PU/PI; for example, immobility, recent weight loss, history of PU/PI, modifiable and non-modifiable risk factors. The plan of care for prevention and/or treatment of PU/PIs will be developed based on the assessments. A resident with current PU/PI's is evaluated/assessed by the licensed nurse at each treatment and as needed. Review of the NPUAP guidelines dated 2014 revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. This deficiency represents non-compliance investigated under Master Complaint Number OH00156481, Complaint Number OH00156247, and Complaint Number OH00155863.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 15816

Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure interventions to promote range of motion and limit contractures were implemented as ordered. This affected two (#24 and #19) of three sampled residents reviewed for range of motion. The facility census was 74.

Findings include:

1. Review of the medical record of Resident #24 revealed an admitted [DATE], with the diagnoses including: cerebral infarction with left side hemiplegia and hemiparesis, right and left lower leg muscle wasting and atrophy, chronic obstructive pulmonary disease, and chronic subdural hemorrhage. According to the minimum data set assessment dated [DATE] assessed Resident #24 with severe cognitive impairment, dependent on staff for the provision of activities of daily living (ADL), limited range of motion impairment on one side to the upper and lower extremities, utilized a wheelchair for mobility and propelled with substantial to maximal assistance from staff.

Review of physician orders revealed on 09/30/22 for a left half lap tray with arm straps for hemiplegic for safe arm positioning was to be applied to the wheelchair every day related to hemiplegia affecting left side.

Review of the plan of care dated 08/28/23 and revised 10/20/23, revealed the plan of care was initiated to address Resident #24's ADL self-care performance deficit related to asphyxiation, chronic obstructive pulmonary disease, hypertension, weakness, impaired balance, left hemiplegia, impaired cognitive functions, depression, muscle wasting and atrophy. Interventions included the following: Place assistive devices within reach. Physical Therapy/Occupational Therapy/Speech Language Pathology screen/ evaluation/treat as needed. Resident uses a manual wheelchair with left half lap tray for locomotion.

Review of the Treatment Administration Record from July 2024 documented the left half lap tray was applied as ordered. No documentation contained in the medical record indicated the lap tray was not available or applied accordingly.

Observations on 07/29/24 at 9:49 A.M., 1:45 P.M., 4:46 P.M., 07/30/24 at 8:35 A.M., and 10:45 A.M., noted Resident #24 seated in a wheelchair. The left armrest had a plastic piece of plastic with jagged edges affixed to the surface. No lap tray was in place. Resident #24 left arm was resting in her lap with the left hand with a closed fist.

Interview on 07/30/24 at 1:55 P.M., interview with State tested Nurse Aide (STNA) #446 during the observations revealed the wheelchair half arm rest had been missing for approximately two weeks. STNA #446 was not aware what happened to the device and also verified jagged plastic edges were identified on the left arm rest.

Interview on 07/30/24 at 2:04 P.M., with Unit Manager Licensed Practical Nurse (LPN) #422 confirmed the half arm rest was missing and not applied to the wheelchair as ordered by the physician.

(continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45445 2. Review of the medical record for Resident #19 revealed an admitted [DATE], diagnoses included: chronic respiratory failure, nontraumatic intracerebral hemorrhage, type 2 diabetes mellitus, depression, anxiety disorder, dysphagia, hypertension, encephalopathy, and bipolar disorder. Resident #19 had a tracheostomy. Review of the annual MDS dated [DATE] revealed Resident #19 had no speech, rarely never is understood and sometimes understands others. Resident #19's cognitive status was unable to be assessed due to a memory problem. Resident #19 had functional impairments to both upper and lower extremities, utilized a wheelchair for mobility and was dependent for mobility, as well Resident #19 was dependent for activities of daily living, and transfers, was always incontinent of bowel and bladder. Review of the care plan dated 09/06/23 revealed Resident #19 had an activities of daily living self-care performance deficit related to contracture's and encephalopathy. Interventions included bathing with the assistance of one person, bed mobility and incontinence care completed with the assistance of two people, and all transfers were completed with a mechanical lift with two staff assistance. Resident #19 had also been cared planned on 02/08/24 for impaired musculoskeletal status related to muscle wasting and atrophy. Interventions included to administer medications and treatments as ordered, observe for fatigue, provide assistance with turning and repositioning as resident will allow, allow ample time to reduce pain, and physical therapy, occupational therapy and speech therapy evaluation and treatment as needed. Review of the current physician orders for Resident #19 revealed an order written on 08/08/23 for rolled wash cloths to both hands every shift, every day and night. Review of the treatment administration record for July 2024 revealed Resident #19 had rolled wash cloths placed in hands on both day and night shift. Observation on 07/29/24 at 5:03 P.M., of Resident #19 revealed the resident sitting upright in bed, with hands tightly clinched. The left hand laying on Resident #19 stomach and the right hand laid alongside Resident #19 body, resting on the mattress. Neither of Resident #19's hands contained a rolled washcloth. Observation on 07/30/24 at 8:03 A.M., revealed Resident #19 lying in bed with eyes closed, head of bed elevated to approximately thirty degrees. The clinched left hand, of Resident #19 was resting on the residents stomach and the clinched right hand laid on the mattress next to Resident #19's body. Both hands were void of rolled wash cloths. Additional observation on 07/30/24 at 2:26 P.M., of Resident #19 sitting in reclining wheelchair in the dining room with residents playing in bingo. No washcloths were observed in Resident #19's tightly clinched hands. The left hand rested on Resident #19's chest and the right hand was alongside Resident #19's body resting on the arm of reclining wheelchair. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/30/24 at 2:35 P.M., with State tested Nursing Assistant (STNA) #477 verified Resident #19 was to have rolled washcloths in both hands. STNA #477 was not sure why the washcloths were not in place. STNA #477 obtained two washcloths and returned to the side of Resident #19 at 2:45 P.M., explained to Resident #19 he was going to place the washcloths in the residents hands. STNA #477 attempted to open Resident #19's left hand and was met with resistance, STNA #477 then attempted to unroll Resident #19's fingers to release them from the resident's palm at which time a foul odor was noted. STNA #477 attempted to slide the washcloth under Resident #19 rolled fingers and into the palm of the hand. [NAME] flakes were noted on washcloth and noted to have dropped on the blouse of Resident #19 when STNA #477 turned and twisted the washcloth in an attempt to place. STNA #47 was unable able to place the washcloth in Resident #19's left hand and stated, I am afraid I am going to break her fingers. STNA #477 then brushed off Resident #19's blouse, grabbed the second washcloth, rolled it and placed in gently under the rolled fingers of the right hand. Additional observation on 07/31/24 at 8:39 A.M. and 12:15 P.M., revealed neither of Resident #19's hands had a rolled washcloth in place. Interview on 07/31/24 at 11:58 A.M., with Therapy Program Director #410 verified Resident #19 is to have rolled washcloths in both hands for the management Resident #19's contracture's and was unaware of the recommended intervention not being followed. Therapy Program Director #410 stated she would talk with nursing and if the rolled washcloth intervention is not working alternative devices that can be used. The Therapy Program Director #410 verified without interventions Resident #19's contracture's would not improve and continue to worsen. A follow-up review of the medical record for Resident #19 revealed an Occupational Therapy note dated 07/31/24 revealed Resident #19 tolerant of functional resting hand position with recommendation to continue wash cloth intervention, staff educated, and unit manager made aware of the needed intervention. Additional observations on 08/01/24 at and 08/05/24 at 9:30 A.M., revealed neither of Resident #19's hands had a rolled washcloth in place. Review of the policy titled Activities of Daily Living, dated 01/01/22, stated the facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on assessment and will maintain individual objectives.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, medical record review, resident interview, staff interview, and review of policy the facility failed to follow their policy to secure resident's smoking materials and failed to ensure residents smoked in the proper designated areas. This affected two (#70 and #13) of three residents reviewed for accidents and hazards. The facility census was 74. Findings Include: 1. Review of Resident #70's medical record revealed an admitted [DATE]. Diagnoses included conductive hearing loss, impacted earwax, and injury of thorax subsequent encounter. Review of Resident #70's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #70 was cognitively intact. Resident #70 required touching assistance with toilet use, bathing, and parts of dressing. Resident #70 displayed no behaviors at the time of the review. Review of Resident #70's care plan revised 05/16/24 revealed supports and interventions for self-care deficit and smoking. Interventions included Resident #70 would be informed of the facility's smoking rules and would be able to verbalize understanding of smoking areas, and storage of smoking materials. The facility would periodically complete a safe smoking evaluation. Review of Resident #70's smoking evaluation completed 05/08/24 revealed Resident #70 as able to smoke safely without smoking aides. Observation on 07/29/24 at 1:22 P.M., of Resident #70 found him sitting up in his wheelchair in his room. Resident #70 had two packs of green packaged cigarettes, one in his hand and one on his bedside stand. Coinciding interview with Resident #70 verified he kept his cigarettes and smoking materials with him. Resident #70 reported he never turned them to anyone and had kept them with him since he had been admitted to the facility. Observation on 07/30/24 at 9:48 A.M., of Resident #70 found him seated outside in his wheelchair under the awning in the front of the building. Resident #70 was smoking. A no smoking sign was posted on the wall approximately 20 feet from where Resident #70 was smoking. Interview on 07/30/24 at 9:50 A.M., with State tested Nursing Assistant (STNA) #463 verified Resident #70 was smoking in front of the building under the awning which was not a designated smoking area. Observation on 07/30/24 at 9:51 A.M., of Resident #70 found STNA #463 reminding him of the proper smoking locations and that he was not permitted to smoke on the facility grounds. Resident #70 was observed finishing his cigarette and putting it out. Resident #70 remained under the awning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included cellulitis, type II diabetes, chronic obstructive pulmonary disease, mild protein calorie malnutrition, osteoarthritis, atrial fibrillation, peripheral vascular disease, major depressive disorder, and dermatitis. Review of Resident #13's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #13 was cognitively intact. Resident #13 was independent with eating and oral care. Resident #13 required moderate assistance with toilet use and bathing. Resident #13 required touching assistance with dressing. Resident #13 displayed no behaviors at the time of the review. Review of Resident #13's care plan revised 06/06/24 revealed supports and interventions for self-care deficit, dental problem related to dentures, discharge plan to discharge to assisted living, risk for falls, risk for impaired mood, pain, and risk for impaired skin integrity. No supports or interventions were found to be in place for smoking. Observation on 07/29/24 at 10:03 A.M., of Resident #13 found him seated in his wheelchair propelling himself into his room. Resident #13 was found to be holding a pack of cigarettes and what appeared to be a burn hole was observed on the front of his green sweater which had brown buttons down the front. Interview on 07/29/24 at 10:04 A.M., with Resident #13 found him to be alert and aware. Resident #13 verified he kept his cigarettes and did not turn them in to anyone. Resident #13 verified the holes in his sweater were burn marks from smoking but reported the holes were old. Resident #13 reported a few days ago the facility staff saw the burns and took his cigarettes from him but after a couple days they returned them to him. Observation on 07/29/24 at 11:28 A.M., of Resident #13 found him smoking a cigarette in the parking lot in front of the facility. Interview on 07/30/24 at 9:45 A.M., with Resident #13 revealed his cigarettes had been taken from him again this morning. Resident #13 stated he was not sure why they took them and was upset because other residents were able to keep their cigarettes and smoke. Interview on 07/30/24 at 9:51 A.M., with State tested Nursing Assistant (STNA) #463 verified Resident #13 was a smoker, had had possession of his cigarettes and they were taken from him this morning. STNA #463 reported Resident #13 was found falling asleep while he was smoking and was burning holes in his clothing so his cigarette's were removed from him for safety reasons. Interview on 07/30/24 at 11:17 A.M., with the Director of Nursing (DON) verified Resident #13's cigarettes were removed from him this morning. A new smoking risk assessment was completed due to Resident #13 burning holes in his clothes and it was determined Resident #13 was not safe to smoke independently. The DON reported it was a non-smoking facility and if there was risk for a resident with smoking they were not able to smoke without supports then they were not permitted to smoke even in the designated areas. The DON reported Resident #13's care plan would be updated to including unsafe smoking. (continued on next page)

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	365523	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Smoking/Non-Smoking Policy, revised 03/12/22, revealed smoking was not permitted inside or outside of the facility on any facility property. Residents with smoking privileges were not permitted to retain any types of smoking articles, to include cigarettes, tobacco etc either on their person or within their living or sleeping area at any time.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on resident interview, staff interview, medical record review, and review of facility policy, the facility failed to provided adequate and timely care to prevent episode of incontinence for a resident who was continent of bowel and bladder. This affected one (#69) of two residents reviewed for bowel and bladder incontinence. The facility census was 74. Findings Include: Review of Resident #69's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis, stroke, peripheral vascular disease, depression, cognitive communication deficit, insomnia, and benign prostatic hyperplasia. Review of Resident #69's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #69 was cognitively intact. Resident #69 was dependent on staff for toilet use and dressing. Resident #69 required maximal assistance with bathing. Resident #69 was not on a toileting program and was noted to be always continent of urine and bowel. Resident #69 displayed no behaviors at the time of the review. Review of Resident #69's care plan revised 07/02/24 revealed supports and interventions for risk for impaired mood, self-care deficit, behaviors of making accusatory statements and sexually inappropriate statements toward staff, risk for falls, and episodes of bladder and bowel incontinence. Interventions for incontinence included assisting resident with toileting as needed, check and change at regular intervals. Review of Resident #69's bowel and bladder incontinence tracking from 07/02/24 through 07/31/24 revealed Resident #69 had no episodes of incontinence. Interview on 07/29/24 at 2:23 P.M., with Resident #69 found him to be alert and aware. Resident #69 reported he knew when he needed to use the bathroom but required staff assistance with getting out of bed and onto the toilet due to left side weakness from his stroke. Resident #69 shared he was on a medication which caused him to have to use the bathroom often even throughout the night. Resident #69 reported about a week ago he put his call light on during the night shift because he needed to use the bathroom. The night staff, he could not recall their name, came in and turned off his light and did not return. Resident #69 reported he ended up soiling himself because he was not assisted to the bathroom. Resident #69 stated he was not assisted until the first shift staff came on and by that point it was too late and he was angry. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/31/24 at 8:17 A.M., with State tested Nursing Assistant (STNA) #478 verified Resident #69 was able to make his needs known and was continent of bowel and bladder. STNA #478 verified a little over a week ago he came to work on first shift and found Resident #69 had soiled himself because he had not been assisted to the bathroom on third shift. STNA #478 reported Resident #69 was very upset because he knew he needed to go but was not provided the assistance he needed and was incontinent because he could not hold it that long. STNA #478 reported he assisted Resident #69 with cleaning up and could understand Resident #69's frustration of not getting the help he needed and soiling himself. STNA #479 stated he would be upset too. Review of the policy titled, Activities of Daily Living, revised 01/01/22, revealed the facility would ensure a resident's abilities in activities of daily living (ADLs) did not deteriorate unless deterioration was unavoidable. This included resident's ability to toilet. Review of the policy titled, Incontinence, revised 01/01/22, revealed the facility must ensure residents who were continent of bladder and bowel upon admission received appropriate treatment, services, and assistance to maintain continence. This deficiency represents non-compliance investigated under Complaint Number OH00156481.