STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365527	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Springfield	1600 Saint Paris Pike Springfield, OH 45504

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, hospital documentation review, staff interviews, policy review, and review of facility initiated corrective action, the facility failed to ensure appropriate treatment and care was provided to prevent a pressure wound from worsening. This resulted in actual harm when Former Resident (FR #35) sustained an unstageable pressure wound from a fracture boot that required debridement and developed an infection. This affected one (FR #35) of four residents reviewed for wounds. The facility census was 34. Findings include: Review of the medical record for FR #35 revealed an admission date of 08/22/22 and discharge date of 07/25/25 with diagnoses including but not limited to fracture of right lower leg, immunodeficiency, chronic kidney disease, type two diabetes with diabetic polyneuropathy, wedge compression fracture of first lumbar vertebra, spinal stenosis lumbar region with neurogenic claudication, major depressive disorder, and need for assistance with personal care. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. FR #35 had an unstageable pressure injury that was not present on admission. Review of the care plan dated 07/26/23 revealed the resident had impaired skin integrity related to chronic end stage renal disease, incontinence of bowel and bladder, and on medications that increase the risk for skin integrity impairment as evidenced by pressure wound to top of right foot from medical device and pressure of right outer foot from medical device initiated on 06/20/25. Interventions included follow up with orthopedic physician as needed for splint initiated on 07/02/25, resident may wear lace up ankle brace if having pain with only ace wrap to right ankle/foot initiated on 06/23/25, administer treatments as ordered initiated on 06/23/25, complete skin inspections weekly and as needed initiated on 06/20/25, and complete wound evaluation to observe the progress of the resident's skin condition.Review of the progress notes from 06/06/25 through 06/20/25 revealed no mention of boot/splint being placed at the orthopedic office. Review of physician orders revealed no orders for boot/splint to be monitored or that the resident had a boot from 06/06/25 through 06/23/25. Review of the after-visit summary dated 06/06/25 from the orthopedic office revealed no mention of the boot or care. Review of the weekly skin assessments revealed no assessments completed from 05/27/25 through 06/10/25 and 06/10/25 through 06/23/25. Review of the Treatment Administration Record (TAR) for June 2025 revealed wound treatment was ordered to be started on 06/21/25. Treatments were completed as ordered as of 06/21/25. Weekly skin assessments signed off on 06/03/25, 06/20/25, and 06/17/25 although only the 06/10/25 skin assessment could be located. Review of the orthopedic visit on 06/20/25 revealed history of present illness for FR #35 presented for routine follow up of right bimalleolar ankle fracture that is being managed nonoperatively due to medical comorbidities. FR #35 stated that he had been keeping the boot in place and ace wrap had not been taken down in the last two weeks. Per the facility, they were not instructed to do any kind of wound care, so they did not remove the dressings or examine the foot. The facility did not reach out to the office regarding the drainage at any point. Significant desquamation and fracture blisters are noted with slough of superficial skin on the dorsum of the foot. Full-thickness dermis loss on the dorsum of the foot without significant ulceration or purulent drainage. The physician had a discussion with the patient on the need for daily dressing changes as soon as possible as there was concern about the state of the skin and the potential for this progressing to an infection that could possibly progress to an amputation. Orders included: referral to wound care, wound change dressings daily, Bactrim DS twice daily, no weight bearing on right foot, and remove boot for wound care and personal hygiene. Review of the orthopedic office visit for 06/27/25 revealed black eschar noted on the dorsum of right foot. Erythema/edema from prior examination significantly improved. No drainage. The physician had a discussion with FR #35 that they were pleased with the progress that the wound team has made on the edema and drainage of the foot. Discussed doing dressing changes twice daily with Silvadene over the eschar and continue Bactrim DS twice daily for another week and return in two weeks. Continue to wear boot, may be removed for dressing changes and showers, remain non weight bearing, continue wound care, continue antibiotic, and apply Silvadene ointment to eschar area. Review of the orthopedic office visit for 07/18/25 revealed FR #35 presented for routine follow up of bimalleolar ankle fracture being managed nonoperatively with open dorsal foot wound that has been managed with wound care. FR #35 reported that his wound dressing changes were not done twice a day as had been ordered. FR #35 reported the last

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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** Based on record review, observation, interview, and policy review, the facility failed to ensure fall interventions were in place. This affected one (#33) of four residents reviewed for falls. The facility census was 34.Findings include:Review of the medical record for Resident #33 revealed an admission date of 07/02/25 with diagnoses including but not limited to anoxic brain damage, respiratory failure, cardiac arrest, and anxiety. Review of the minimum data set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. Resident #33 was dependent on staff for activities of daily living.Review of the care plan dated 10/07/25 revealed the resident was at risk for falls related to anoxic brain damage and muscle weakness. Interventions included perimeter overlay to air mattress and low bed.Observation on 10/20/25 at 1:27 P.M. of Resident #33 revealed the resident was lying in bed with an air mattress and the bed was in high position approximately chest high to surveyor with no one in the room.Interview on 10/20/25 at 1:32 P.M. with Certified Nursing Assistant (CNA #118) verified the bed was in high position with no one in the room. CNA #118 stated the resident's husband was in the room prior and would raise the bed when he visited. CNA #118 verified the husband was no longer at the facility and the bed was not lowered per care plan.Review of policy titled, Fall Prevention Program, dated 10/26/23 revealed the nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan. Interventions will be monitored for effectiveness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure proper hand hygiene was completed during a dressing change. This affected one (#7) resident of one resident observed for wound care. The facility census was 34.Findings include:Review of the medical record for Resident #7 revealed an admission date of 07/09/25 with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), chronic kidney disease stage four, dependence on respirator (ventilator) status, anxiety, and need for assistance with personal care.Review of the minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact. The resident was dependent on staff for activities of daily living.Review of the physician order revealed right lower abdomen cleanse with normal saline, pat dry, apply moistened collagen and cover with foam dressing three times weekly and as needed.Observation on 10/20/25 at 2:16 P.M. of wound care with Licensed Practical Nurse (LPN #205) for Resident #7 revealed LPN #205 gathered supplies which included calcium alginate, scissors, normal saline vial, soft silicone foam dressing, and four by four dressings. LPN #205 cleaned scissors with an alcohol pad and placed them on clean trash bag laid out on treatment cart along with the dressing supplies. LPN #205 knocked on door, entered room and explained to the resident what she was going to do. Resident agreeable to dressing change. LPN #205 then washed hands, donned a gown and placed a clean barrier to cover the bed table and arranged the supplies. LPN #205 donned gloves and removed the old dressing from the residents right lower abdomen. Wound appeared beefy red and peri wound was intact. No odor was noted. LPN #205 then removed her gloves and donned a new pair of gloves. LPN #205 then opened four by four gauze packages and cleansed the wound with normal saline. LPN #205 removed gloves and donned new gloves. LPN #205 placed calcium alginate in the wound and opened the silicone foam dressing. LPN #205 stated that she would date the dressing prior to applying it to the resident. LPN #205 removed her gloves and dated the dressing. LPN #205 donned new gloves and placed the foam dressing over the wound. LPN #205 was not observed to wash or sanitize hands after removing soiled gloves and donning clean gloves on four occasions. Interview on 10/20/25 at 2:42 P.M. with LPN #205 revealed the nurse verified she did not wash or sanitize hands between glove changes. LPN #205 verified she was supposed to wash hands or sanitize hands prior to donning new gloves. Review of policy titled, Clean Dressing Change, dated 12/28/23 revealed policy explanation and compliance guidelines: explain the procedure to the resident and screen for privacy, multi-use wound care supplies should be dated and initialed when opened, set up clean field with needed supplies for wound cleansing and dressing application, establish area for soiled products to be placed, wash hands and put on clean gloves, place a barrier cloth or pad next to the resident under the wound to protect the bed linen and other body sited, loosen the tape and remove the existing dressing, remove gloves, wash hands and put on clean gloves, cleanse the wound as ordered, measure wound, wash hands and put on clean gloves, apply topical ointments or creams and dress the wound as ordered, secure dressing mark with date and initials, discard disposable items and gloves into appropriate receptacle and wash hands.