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	10/24/2024

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

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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 - Some	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** 36303 Based on record review, interview and policy review, the failed to hold care conferences for residents. This affected nine (Residents #3, #8, #10, #12, #14, #17, #27, #28, and #34) of 13 residents reviewed. The census was 33. Findings include: 1. Review of Resident #8's medical record revealed an admitted d of 01/19/24. Quarterly MDS assessments were completed on 02/09/24, 05/11/24, 08/11/24, and 09/22/24. Review of Resident #8's medical record revealed a care conference was held on 02/20/24. No further care conferences were held. 2. Review of Resident #10's medical record revealed an admitted d of 09/08/22. MDS assessments were completed on 02/22/24, 04/04/24, 04/15/24, and 06/11/24, and 09/09/24. Review of Resident #10's medical record revealed a care conference was held on 01/24/24. No further care conferences were held. 3. Review of Resident #27's medical record revealed an admitted d of 08/17/23. MDS assessments were completed on 05/06/24 and 08/24/24. Review of Resident #27's medical record revealed a care conference was held on 11/01/23. No further care conferences were held. 37447 4. Review of the medical record for Resident #17 revealed she was admitted [DATE]. Resident #17 had MDS assessments competed on 02/24/24, 05/26/24 and 08/26/24. Only one care conference was held, on 01/24/24. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 3:56 P.M., Social Services Designee (SSD) #80 verified the January care conference was the only conference held this year for Resident #17. 5. Review of the medical record for Resident #28 revealed he was admitted initially 11/07/23 with re-entry 03/16/24. Resident #28 had MDS assessments completed on 03/28/24, 06/20/24 and 09/20/24. Only one care conference was held, on 02/01/24. During an interview on 10/22/24 at 3:42 P. M. the Director of Nursing (DON) confirmed care conferences should be held quarterly. During an interview on 10/22/24 at 3:56 by the Social Services Designee (SSD #80) he verified the February care conference was the only conference held this year. 45751 6. Review of medical record for Resident #3 revealed an admitted [DATE]. The most recent MDS assessment was completed on 07/10/24. Review of the Care Conference Summaries revealed the last care conference held was on 01/31/24. 7. Review of medical record for Resident #12 revealed an admitted [DATE]. The most recent MDS assessment was completed on 07/26/24. Review of Care Conference Summaries revealed the last care conference was held on 02/21/23. During an interview on 10/22/24 at 4:00 P.M., SSD #80 stated they did not hold a care conference for Resident #12 due to the resident has a court appointed guardian and the guardian did not want to be included in any care conferences. SSD #80 was not aware that a care conference with the interdisciplinary team should be held quarterly even if the guardian did not want to attend. 8. Review of medical record for Resident #14 revealed an admitted [DATE]. The most recent MDS assessment was completed on 09/23/24. Review of Care Conference Summaries revealed the last care conference was held on 01/26/24. 9. Review of medical record for Resident #34 revealed an admitted [DATE]. The most recent MDS assessment was completed on 09/17/24. Review of the Discharge Planning Evaluation dated 06/12/24 revealed the facility indicated that it was the initial care conference. No other care conference documentation was provided by the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 4:00 P.M., SSD #80 verified the care conferences were not held quarterly for Residents # 3, #8, #10, #12, #14, #17, #27, #28, and #34. Review of policy titled Participation in 72 Hour Care Review- Assessment/Care Plans, dated 03/20/24, revealed the comprehensive care conference is scheduled after the completion of the comprehensive care plan and quarterly. Document the outcome of this meeting in the progress notes. This care conference should be attended by Social Services, Dietary, Activities, and Nursing.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34291 Based on observation, record review, interview and policy review, the facility failed to ensure a resident received podiatry services and failed to ensure baths and showers were provided to residents. This affected two (Residents #13 and #3) of three residents reviewed for activities of daily living. The census was 33. Findings include: 1. Record review revealed Resident #13 revealed an admitted [DATE]. Medical diagnoses included unilateral primary osteoarthritis of the left knee, diabetes, and Alzheimer's disease. Review of the podiatry visits revealed the last visit for Resident #13 was 04/28/22. Review of podiatry Do Not Treat list, dated 03/25/24, revealed Resident #13 was on the list labeled as other. There were no notes in Resident #13's record related to not being treated by the podiatrist. During an observation on 10/21/24 at 9:52 A.M., Resident #13 had long, thick, yellow toenails. Review of list of patients to be seen by the podiatrist on 10/25/24 did not include Resident #13. During an interview on 10/23/24 at 2:15 P.M., the Director of Nursing stated it was the responsibility of the facility to trim the nails of the residents by the staff or an outside service. She confirmed Resident #13's toenails were long and thick and hadn't been trimmed in a while. She said she couldn't trim them since they were thick, and she would add Resident #13 to the podiatry list. She said she didn't know why Resident #13 was on the Do Not Treat list. 45751 2. Record review revealed Resident #3 was admitted on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, lymphedema, dependence on respirator (ventilator) status, depression, and tracheostomy status. Review of Care Plan dated 10/16/24 revealed the resident had an ADL self-care deficit related to vent dependency. The resident required the assistance of two staff for bathing and required a mechanical lift for transfers. Review of shower documentation for September 2024 revealed the residents shower days were Wednesday and Saturday on day shift. No documentation for for shower or bed bath was noted on 09/14/24, 09/18/24, and 09/21/24. Review of shower documentation for October 2024 revealed no documentation for shower or bed bath was noted on 10/02/24, 10/09/24, and 10/12/24. The resident refused on 10/19/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 9:00 A.M., Resident #3 stated she did not get washed up like she should. During an interview on 10/22/24 at 2:19 P.M., Resident #3 stated her shower days are Wednesday and Saturday and that she takes a bed bath instead of a shower. Resident #3 stated she does not always receive her bed bath on the scheduled days. Resident #3 stated she may have refused once in the last two months. During an interview on 10/22/24 at 2:28 P.M., the DON verified that the showers or bed baths were not documented as given on 09/14/24, 09/18/24, 09/21/24, 10/02/24, 10/09/24, and 10/12/24. Review of the policy entitled Nail Care dated 08/20/24 revealed the purpose of this procedure is to provide guidelines for the care of a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: 1. Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible. a. Report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g., curling, color changes, separation from the nail bed, redness, bleeding, pain, odor, infection,etc.). b. Obtain history and preferences regarding podiatrist. 2. Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke. 3. Routine cleaning and inspection of nails will be provided during ADL care ongoing. 4. Routine nail care, to include trimming and filing, will be provided on a regular basis and as the need arises. 5. Principles of nail care: a. Nails should be kept smooth to avoid skin injury. b. Only podiatrists, physician/practitioners, or licensed nurse shall trim toenails for residents with diabetes or circulation problems. c. Each resident will have his/her own nail care equipment (e.g., clippers, emery boards, files, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	etc.). Equipment will not be shared between residents. Clean equipment after each use and before storing. Review of policy titled Activities of Daily Living (ADLS) dated 10/26/23 revealed a resident who is unable to carryout ADLs will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Number OH00158346.

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F 0689 Level of Harm - 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** 34291 Based on record review, staff interviews, and policy review, the facility failed to ensure proper positioning technique for safe bed mobility was implemented which resulted in a major fall with injury. The facility also failed to ensure a fall investigation was completed that included root cause analysis. This resulted in Actual Harm when Resident #30, who was severely cognitively impaired, at risk for falls and dependent on staff for turning and repositioning sustained a fall when two staff members were providing incontinent care and the resident fell to the floor face first due to improper positioning technique. This affected one (Resident #30) of three residents reviewed for falls. The census was 33. Findings include: Record review revealed Resident #30 was admitted of [DATE]. Medical diagnoses included anoxic brain injury, anemia, hypertension, renal failure, pneumonia, diabetes, acute respiratory failure with hypoxia, cardiac arrest, morbid obesity, encephalopathy, and need for assistance for personal care. She weighed 369 pounds. Review of care plan dated [DATE] revealed Resident #30 was at risk for activities of daily living self-care deficit related to anoxic brain injury damage and morbid obesity. Interventions were a two-person assistance for bed mobility, toileting, transfers with the use of the Hoyer lift. Resident #30 had acquired absence of the left leg below the knee, and she was ventilator dependent. She was at risk for falls with injury due to an anoxic brain injury. The intervention was to ensure the resident's room was free from accident hazards, providing adequate lighting ensuring there was no trip hazards. Review of fall risk assessment dated [DATE] revealed Resident #30 was a high fall risk. Review of quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #30 was rarely or never understood. She was impaired to the lower left extremity. She didn't exhibit any signs or behaviors. Her functional status was dependent on toileting, bathing, and bed mobility. Eating and transfers were not attempted due to medical condition or safety concerns. She was always incontinent of bowel and bladder. She used a mechanical ventilator, had a tracheostomy, feeding tube, and oxygen. Review of the progress notes dated [DATE] at 5:00 P.M. revealed Resident #30 rolled from a wet mattress to the floor. Care was provided by State tested Nursing Assistants (STNA) #80 and #102. An assessment was completed, and the physician was notified. Neurological (neuro) testing was initiated, and the results were at baseline. There was swelling to the left eye. Her temperature was 97.3 degrees Fahrenheit (F), pulse 64, respirations 18, blood pressure ,d+[DATE], and oxygen saturation was 94 percent. The resident was transferred back to bed by a Hoyer lift and the family was notified. The neuro testing continued. On [DATE] at 2:48 P.M., swelling to the left eye continued. On [DATE] at 5:30 A.M., Resident #30 was transferred to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a witness statement from STNA #80 dated [DATE] revealed he and STNA #102 were cleaning Resident #30 up and when rolling her onto her side she jerked and slid off the bed. STNA #102 tried to slow her down and she was too much weight to hold. The STNAs moved the bed out of the way and alerted the nurse. A review of a witness statement from STNA #120 dated [DATE] revealed he and STNA #80 went into the room to clean Resident #30. They went to roll the resident to her side to remove the linens and put new down and the resident coughed, and the vent popped off. STNA #120 grabbed the vent, and the resident slid off the bed and STNA #120 tried to catch her, and she fell to the floor. Review of the witness statement from Licensed Practical Nurse (LPN) 56, dated [DATE] at 5:00 P.M., revealed STNA's #120 and #80 called her to Resident #30's room. Resident #30 was lying on the floor on her back. The resident had swelling to the left side of her head and face and her eye was swollen shut. Resident #30 was at baseline for cognition, pupils reactive, range of motion (ROM) was negative for pain and dislocation. After the assessment was completed, the resident was placed in a Hoyer lift and put back to bed and neuro checks continued. Review of progress note dated [DATE] at 11:57 P.M. revealed the admitting hospital diagnoses for Resident #30 were subdural hematoma and subgaleal hematoma. Review of the investigation report for Resident #30, dated [DATE], revealed STNAs #120 and #80 were providing incontinent care to the resident when they rolled the resident to the right side. The vent tubing disconnected, and the aide grabbed tubing when the resident continued to roll out of the bed onto floor, hitting the left side of her face. Vent tubing was reconnected, the nurse was alerted immediately, and assessment was completed with the physician on the phone. The resident was opening eyes with swelling noted to left eye brow. Range of motion was performed to all extremities without deficit, no deficit in pupils and they were equal, round, and reactive to light and accommodation (PERLLA) from resident's baseline PERRLA. The resident has anoxic brain injury and only opens eyes at baseline, no signs of distress, to continue to monitor neuro checks and swelling. The family was made aware of the incident. Assisted up to bed with six staff members who assisted with the Hoyer lift. Resident monitored throughout night when swelling to face increased, the physician was in the facility on [DATE] at 5:30 A.M. to round and assessed the resident with an order to send to the hospital for evaluation. The scan was completed and revealed subdural hematoma and subgaleal hematoma. No root cause analysis for the fall was provided by the facility. Review of the discharge hospital records dated [DATE] revealed Resident #30 had fallen out of bed at the nursing facility. She hit her head, and the CT scan showed there was a small subdural hematoma and subgaleal hematoma. A repeat CT scan was done, and it showed the subdural hematoma changes were stable, and no surgery was planned. The resident was found to have lower lobe pneumonia, probable urinary tract infection and was also septic. The family met with the physicians on [DATE] at 4:02 PM. at the hospital and discussed the terminal prognosis and the family decided that living on life support was not acceptable for the resident. The resident expired on [DATE] at 6:30 P.M. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 7:40 A.M., the Director of Nursing (DON) stated Resident #30 didn't expire because of the fall. It was identified at the hospital that the resident had a small subdural hematoma (that was stable) pneumonia and probable urinary tract infection. She stated the family decided to remove the ventilator and initiate hospice care for her. She stated the aides followed the care plan for two-person assistance and her investigation revealed the facility wasn't at fault for anything. She did acknowledge something happened in the room but wasn't sure what it was because she wasn't in the room the time it happened. She didn't know the resident was placed on the edge of the bed at the time of the fall either and didn't get that in her investigation. She revealed the interdisciplinary team (IDT) talked about a root cause analysis, but didn't write anything down in the record. During an interview on [DATE] at 9:35 A.M., STNA #80 stated he was helping STNA #102 with incontinence care for Resident #30 on [DATE] around 4:45 P.M. He stated he was standing on the left side of the bed. He grabbed the draw sheet and moved the resident toward him and then rolled her over to the edge of the bed. He said her ventilator popped off. STNA #102 grabbed the ventilator hose to put back on the resident and the resident went onto the floor hitting the left side of her face on the feed tubing pole and then to the floor face first. He said he tried to grab her from across from the bed, but it happened so fast he couldn't reach her. He stated STNA #102 tried to break her fall but couldn't. During an interview on [DATE] at 11:01 A.M., STNA #102 revealed he was the aide who provided incontinence care with STNA #80 on [DATE] at 4:45 P.M. He stated he was on the right side of the bed and was holding onto the resident when STNA #120 rolled her to him. He stated she was on the edge of the bed and his body was placed in the middle of the bed to the lower end of the bed, because that was where the most weight was. He said when she was turned toward him and she was up against his body, her ventilator tubing came out and she was gurgling and coughing. He reached behind her left shoulder, because the tubing fell on to the bed and when he reached, she fell on to the left side of her face into the feeding tube pole and tumbled to the ground. He said it all happened so fast. He said he went and got the nurse. During an interview on [DATE] at 10:03 A.M., the Medical Director (MD) 124 stated she remembered the staff calling her on the evening of [DATE]. She asked the usual questions when someone hit their head. The questions were how they fell , was the fall witnessed, did the resident strike their head, was their skin broken, was there any blood, injuries, medications the resident was on, and if the resident had loss of consciousness. She stated it was determined to keep the resident in the facility and do the neuro checks. She said the facility would need to call her service if they weren't able to do the neuro checks and they didn't call. She said Nurse Practitioner (NP) 126 came in the morning of [DATE] at 5:30 A.M. and the resident didn't look good. She called the physician and it was decided to send her out to the hospital. Review of the policy titled Falls Protocol, dated [DATE], revealed as part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling. This deficiency represents non-compliance investigated under Complaint Numbers OH00159043, OH00158875 and OH00158872.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, record review, and interview the facility failed to ensure the tube feeding bag and syringe was changed per the physician order. This affected two (Residents #34 and #191) of three residents reviewed for tube feeding. The facility census was 33. Findings include: 1. Record review revealed Resident #34 was admitted on [DATE]. Diagnoses included anoxic brain damage, respiratory failure with hypoxia, cardiac arrest, encephalopathy, hypertension, anxiety, and acute gastric ulcer without hemorrhage or perforation. Review of Minimum Data Set (MDS) assessment, dated 09/17/24, revealed Resident #34 was severely cognitively impaired and required enteral nutrition (tube feeding). Review of current physician orders revealed to change the feeding syringe on night shift, label with residents name and date. During an observation on 10/22/24 at 10:08 A.M., the tube feeding syringe was laying on the nightstand unwrapped with no date or name. The graduated cup was dated 10/06/24. No plastic bag was observed in the room for the tube feed syringe to be stored in. During an interview on 10/22/24 at 10:13 A.M., Med Tech #69 verified the tube feed syringe was not dated nor in plastic sleeve and that the graduated cup was dated 10/06/24. Med Tech #69 stated she was unsure when the graduated cups had to be changed but she believed it was weekly. Med Tech #69 verified the tube feed syringe was to be changed daily on night shift. 2. Record review revealed Resident #191 was admitted on [DATE]. Diagnoses included amyotrophic lateral sclerosis, acute on chronic respiratory failure, dependence on respirator, asthma, progressive bulbar palsy, gastrostomy status, and dysphagia. Review of the MDS dated [DATE] revealed the resident was severely cognitively impaired and required enteral nutrition. Review of current physician orders revealed to change feeding syringe and/or container daily on night shift, label with resident name and date, [NAME] Farms tube feeding 1.4 at 55 milliliters per hour (ml/h) continuous to equal 1320 calories, may hold for care. During an observation on 10/21/24 at 9:09 A.M., the tube feed hanging on the pole was dated 10/16/24. A visitor in the room at that time stated they were told the facility ran out of bags for the tube feed. During an interview on 10/21/24 at 9:16 A.M., Licensed Practical Nurse (LPN) #56 verified the tube feed bag hanging on the pole was dated 10/16/24. LPN #56 told the visitor in the room that the facility had bags and she would hang a new one. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 9:54 A.M., Central Supply Staff #115 stated they did not run out of tube feed bags for Resident #191. Central Supply Staff #115 stated she has a whole box of bags in the supply room and they would not have run out of bags over the weekend. During an interview on 10/22/24 at 1:18 P.M., LPN #104 stated the bags were to be changed daily on night shift. The tube feed bags were not a closed system and the bag had to be opened to pour the tube feed into the bag.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on record review, interview and policy review, the facility failed to ensure a narcotic medication was given to a resident on hospice care in a timely manner. This affected one (Resident #13) of one residents reviewed for Oxycodone administration. The census was 33. Findings include: Record review revealed Resident #13 was admitted on [DATE]. Medical diagnoses included unilateral primary osteoarthritis of the left knee, diabetes, and Alzheimer's disease. Resident #13 had a physician order dated 05/09/24 for Oxycodone five milligrams (mg), give one by mouth twice a day for pain. Review of care plan dated 07/26/24 revealed Resident #13 has a terminal prognoses with hospice care related to Alzheimer's. Interventions were to administer medications as ordered and observe for effectiveness. Also evaluate for verbal and non-verbal signs and symptoms related to pain. Review of annual Minimum Data Set (MDS) assessment, dated 08/09/24, revealed Resident #13 was severely cognitively impaired. Review of the progress note dated 10/09/24 at 8:41 A.M. revealed the resident was out of Oxycodone. Hospice was notified and per hospice, the prescription will be sent to the pharmacy. On 10/10/24 at 9:55 A.M. hospice was notified to send the prescription for Oxycodone to pharmacy. On 10/12/24 at 8:53 A.M. the pharmacy was called about Resident #13's Oxycodone and the pharmacy was waiting on the prescription. The nurse contacted hospice regarding the prescription and the receptionist will have nurse call the facility back. At 9:21 A.M. the hospice nurse called the facility and stated they would call in the prescription. Review of the Medication Administration Record (MAR) dated 10/09/24 through 10/23/24 revealed the resident wasn't given Oxycodone five mg two times a day on 10/09/24, 10/10/24, 10/11/24, or 10/12/24. Review of the notes revealed there were no concerns regarding Resident #14 being in pain during this time. During an interview on 10/23/24 at 2:31 P.M., the Director of Nursing stated the Oxycodone wasn't given to the resident because the facility couldn't get them, and they wouldn't be able to pull out of the emergency box because the physician has to write a new prescription. She said the resident was monitored and she wasn't in any pain or withdrawal. During an interview on 10/24/24 at 7:16 A.M., Registered Nurse (RN) #103 stated someone didn't order the medication for Resident #13 and confirmed she went four days without the Oxycodone. (continued on next page)

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	10/24/2024

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Pain Management, dated 10/26/23, revealed the facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goal and preferences.

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	10/24/2024

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review and staff interview, the facility failed to discontinue a medication as ordered. This affected one (Resident #8) of six residents reviewed for medications. The census was 33. Findings include: Record review revealed Resident #8 was admitted on [DATE]. Diagnoses included bronchopneumonia, anxiety disorder, obstructive sleep apnea, acute and chronic respiratory failure, and dependence on a ventilator. Review of the pharmacy recommendations revealed a recommendation dated 05/10/24 to discontinue Prevacid DR capsule (heartburn medication) due it should not be crushed. Resident #8's physician signed the recommendation on 05/22/24 to discontinue Prevacid DR. Review of a pharmacy recommendation dated 07/06/24 revealed a recommendation to again discontinue Prevacid DR due to it not being discontinued in May 2024. Resident #8's physician signed the recommendation on 07/25/24 to discontinue Prevacid DR. Review of medication administration records (MAR) revealed Resident #8 received Prevacid DR 30 milligrams (mg) twice day from 05/22/24 to 07/25/24. During an interview on 10/22/24 at 9:27 A.M., the Director of Nursing verified the medication was not discontinued as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00158346.

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	10/24/2024

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Arbors at Springfield	1600 Saint Paris Pike Springfield, OH 45504

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37447 Based on record review and interview, the facility failed to ensure pharmacy recommendations were addressed timely by the physician resulting in extended duplicate selective serotonin reuptake inhibitors (SSRI) therapy. This affected one (Resident #28) of five residents reviewed for unnecessary medications. The facility census was 33. Findings include: Record review revealed Resident #28 was initially admitted on [DATE] with re-entry 03/16/24. His diagnoses included congestive heart failure, type 1 diabetes, moderate protein-calorie malnutrition, chronic kidney disease stage 4, anxiety disorder, anemia, insomnia, hypertension, and hypothyroidism. Review of the Minimum Data Set (MDS) assessment, dated 09/20/24, revealed Resident #28 was cognitively intact. intact. Review of a pharmacy recommendation dated 08/07/24 recommended discontinuing one of his two SSRI medications to decrease the risk of serotonin syndrome. This recommendation was not reviewed, agreed to and signed until 10/08/24. Review of the Medication Administration Record (MAR) for August, September and October for Resident #28 revealed he continued to receive duplicate SSRI therapy from 08/07/24 until 10/08/24. During an interview on 10/22/24 at 3:40 P.M., the Director of Nursing confirmed the pharmacy recommendation was not addressed timely.

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	10/24/2024

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

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on record review and interview, the facility failed to obtain laboratory values as planned by the practitioner. This affected one (Resident #141) of six residents reviewed for unnecessary medications. The census was 33. Findings include: Review of Resident #141's closed medical record revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, dependence on a ventilator, pneumonia, and cerebral infarction. Resident #141 was discharged from the facility to a local hospital on 09/21/24 and did not return. Review of nurse practitioner (NP) progress notes dated 09/19/24 at 8:31 A.M. revealed Resident #141 had been having loose stools with recent antibiotic use. Plan was stool checked for clostridium difficile (C-diff), complete blood count (CBC), and basic metabolic panel (BMP) were ordered. Review of physician orders revealed no order dated 09/19/24 and review of lab results revealed nothing for a CBC, BMP, and C-diff. During an interview on 10/23/24 at 1:30 P.M., the DON confirmed the CBC, BMP, and C-diff had not been ordered or obtained. The orders are entered directly into the lab's computer system by the practitioner. Nothing is kept in the electronic medical record. This deficiency represents non-compliance investigated under Complaint Number OH00158346.