STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365674	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49041 Based on medical record review, review of a facility Self-Reported Incident, interviews and policy review, the facility failed to prevent an incident of resident to resident sexual abuse. This affected one resident (Resident #44) of four residents reviewed for abuse. The facility census was 74. Findings Include: Review of the facility self reported incident (SRI) tracking number 248709 dated 06/17/24 at 9:54 A.M. revealed an allegation or suspicion of sexual abuse. Local Law enforcement was contacted , and an officer came out to complete a report, #24-0212. Resident #7 was placed on one to one supervision. The facility investigation was completed on 06/24/24 at 12:35 P.M. with the allegation of sexual abuse being substantiated. An interview on 06/24/24 with State tested Nurse Aide (STNA) #505 revealed witnessing inappropriate touching between Resident # 7 and Resident #44. STNA #505 indicated that Resident #7 was sitting next to Resident# 44 in the common dining area at approximately 9:51 A.M. on 06/16/24. Resident #7 reached over and touched Resident #44's breast over the clothing. Resident #7 was immediately instructed to keep his hands to himself, and Resident #7 and Resident #44 were immediately separated. STNA #505 revealed the total incident lasted less than 30 seconds. a. Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included dementia, atrial fibrillation (abnormal heart rhythm), hypertension, sick sinus syndrome (abnormal heart rhythms), osteoarthritis, chronic kidney disease, and cognitive communication deficit. Review of the Resident #44's quarterly Minimum Data Set (MDS) assessment, dated 05/10/24, revealed the resident had severely impaired cognition. Review of Resident #44's skin assessment dated [DATE] revealed no abnormal skin areas. An interview was attempted on 06/24/24 at 8:50 A.M., with Resident #44, but she was unable to recall the incident occurring on 06/16/24. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Resident #7's medical records revealed admitted [DATE]. Diagnoses included degeneration of the nervous system, major depressive disorder, alcohol abuse, mild cognitive impairment, transient cerebral infarction, hemiplegia (paralysis) and hemiparesis (muscle weakness) of right side of the body Review of the Resident #7 quarterly Minimum Data Set (MDS) assessment, dated 04/03/24 revealed mild cognitive impairment. An interview on 06/24/24 at 9:11 A.M., with Resident #7, revealed he didn't understand why this was a big deal. Resident #7 indicated that Resident #44 was a friend and before he touched her breast, he asked permission and permission was granted by Resident #44. Review of Resident #7's care plan dated 04/03/24 revealed Resident #7 demonstrated verbally aggressive behaviors usually directed at staff. Review of the Resident #7's nursing progress note dated 06/16/24 revealed Resident #7 was placed on one-to-one supervision following the allegation of inappropriate touching. Review of Resident # 7's nursing progress notes from 03/01/24 through 06/24/24 revealed sporadic documentation of verbal aggression primarily directed toward staff when redirecting the resident. Review of The Psychiatry Progress notes signed by Nurse Practitioner #510 on 03/13/24 and 04/11/24 revealed no indication of sexually inappropriate behaviors and Resident #7 was psychiatrically stable. An interview with the Administrator on 06/25/24 at 12:07 P.M. verified the incident of inappropriate touching by Resident #7 of Resident #44 clothed breast area occurred on 06/16/24 at 9:51 A.M. Review of facility policy titled Abuse, Neglect and Exploitation dated 01/10/24, revealed the facility will implement policies and procedures to prevent and prohibit all types of sexual abuse, neglect, and misappropriation of resident property that establishes a safe environment This deficiency represent non-compliance investigated under Complaint Number OH00154973.

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Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49041 Based on medical record review , review of a facility self-reported incident, policy review and interviews the facility failed to timely report an allegation of resident to resident sexual abuse to the administrator and state survey agency. This affected one resident (Resident #44) of four residents reviewed for abuse. The facility census was 74. Findings Include: Review of the facility self reported incident (SRI) tracking number 248709 dated 06/17/24 at 9:54 A.M. revealed an allegation or suspicion of sexual abuse. Local Law enforcement was contacted , and an officer came out to complete a report, #24-0212. Resident #7 was placed on one to one supervision. The facility investigation was completed on 06/24/24 at 12:35 P.M. with the allegation of sexual abuse being substantiated. An interview on 06/24/24 with State tested Nurse's Aide (STNA) #505 revealed they witnessed inappropriate touching between Resident #7 and Resident #44. STNA #505 indicated that Resident #7 was sitting next to Resident #44, in the common dining area at approximately 9:51 A.M. on 06/16/24, and Resident #7 reached over and touched Resident #44's breast, over the clothing. Resident #7 was immediately instructed to keep his hands to himself, and Resident #7 and Resident #44 were immediately separated. STNA #505 revealed the incident lasted less than 30 seconds. STNA #505 revealed they completed a witness statement on 06/16/24 and placed it under the door of the Administrator's office. a. Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included dementia, atrial fibrillation (abnormal heart rhythm), hypertension, sick sinus syndrome (abnormal heart rhythms), osteoarthritis, chronic kidney disease, and cognitive communication deficit. Review of the Resident #44's quarterly Minimum Data Set (MDS) assessment, dated 05/10/24, revealed the resident had severely impaired cognition. b. Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses included degeneration of the nervous system, major depressive disorder, alcohol abuse, mild cognitive impairment, transient cerebral infarction, hemiplegia (paralysis) and hemiparesis (muscle weakness) of right side of the body Review of Resident #7's quarterly MDS assessment, dated 04/03/24, revealed the resident had mild cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 06/25/24 at 12:07 P.M. verified the incident of inappropriate touching by Resident #7 to Resident #44's clothed breast area, occurred on 06/16/24 at 9:51 A.M. The Administrator was made aware of the situation on 06/17/24 upon arrival to the facility on [DATE] at approximately 8:35 A. M. when a witness statement was found in their office. The witness statement had been slipped under their door and was signed by STNA # 505. A Self-Reported Incident (SRI) was started on 06/17/24 at 9:54 A.M. and a facility investigation was initiated and completed on 06/24/24 at 12:35 P.M. Lastly, the Administrator verified the allegation was not reported to the Administrator and the state survey agency within two hours of the incident, as required. Review of the facility Abuse, Neglect, and Exploitation Policy dated 01/10/24 revealed an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur and the reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies immediately, but no later than two hours after the allegation involving abuse or result in serious bodily harm. This deficiency represents non-compliance investigated under Complaint Number OH00154973.