STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365674	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, policy review, and interview, the facility failed to ensure physician notification occurred with a change in resident condition . This affected one (Resident#1) of three reviewed for change in condition. Findings include: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included paraplegia, morbid obesity, obstructive hydrocephalus, presence of cerebrospinal fluid drainage device, major depressive disorder, and abnormal posture. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition. The resident required physical assistance with activities of daily living. Review of the nursing progress note dated [DATE] at 11:30 A.M. revealed the resident received Zofran 4 mg (ordered [DATE]) by mouth for nausea and vomiting. The administration was listed as effective. Review of the nursing progress note dated [DATE] at 8:55 A.M. revealed Resident #1 had frequent episodes of emesis for the last three days and was unable to keep medications, fluids, and food down. The physician was notified. Review of the nursing progress note dated [DATE] at 3:34 P.M. revealed a physician order was given for promethazine 12.5 mg intramuscularly (IM) injection to be given every six hours as needed for nausea and vomiting. Review of the Medication Administration Record, dated [DATE], revealed Resident #1 was administered promethazine 12.5 mg IM on [DATE] at 3:56 P.M. and 10:38 P.M. The medication administration was noted to be effective. Review of the nursing progress note dated [DATE] at 1:48 A.M. (authored by LPN #200) revealed brown colored emesis, varying from thick to watery. Vital signs: blood pressure ,d+[DATE], pulse 120, respirations 20, and oxygen saturation 90% on room air. Physician notified. (There was no information documented in regards to how the physician was notified or what information was provided to the physician during the notification). (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: 365674	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER: Arbors at Minerva		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated [DATE] at 1:54 A.M. (authored by LPN #200) revealed acetaminophen 325 mg, two tablets, were given for pain. Review of the nursing progress note dated [DATE] at 5:15 A.M. (authored by LPN #200) revealed this nurse went into resident's room to re-assess after Tylenol was given at 1:45 A.M. The resident stated she was not feeling right. This nurse observed the resident to have short, rapid respirations, her skin was cold and moist, pale in color. This nurse attempted to obtain another full set of vital signs; blood pressure was unable to be read, oxygen saturation was 76% on room air, and temperature was 96.2. Oxygen was applied via nasal cannula and the physician was notified. An order was given to send the resident to the ER. EMS was notified of the emergency need of transport. Second nurse arrived to assist this nurse (LPN #200), and the Director of Nursing (DON) was notified of the resident's rapid change in condition. This nurse grabbed the crash cart and automated external defibrillator (AED) from the wall. At 4:49 A.M. CPR was initiated by this nurse and second nurse. EMS arrive at 4:51 A.M. and stated they were unaware of need for an emergency and had to go back out to the ambulance to retrieve equipment. CPR was continued by nursing staff. Resident #1 was intubated. After 20 minutes, an emergency medical technician (EMT) told the nursing staff to stop CPR and called an ER doctor to get the time of death. The physician, DON, and power-of-attorney were notified. Interview on at [DATE] at 1:51 P.M. with LPN #200 revealed on [DATE], Resident #1 had complained of not feeling well and had vomited brown emesis. LPN #200 stated she administered Tylenol at this time. LPN#200 stated she went back to re-assess Resident #1 and the resident complained that she didn't feel well. LPN #200 stated she was unable to obtain a blood pressure reading and the resident's oxygen saturation was low, so she notified the physician, who ordered the resident to be sent to the ER. LPN #200 stated the resident continued to decline and coded about one minute prior to the arrival of EMS. LPN #200 stated she and LPN #290 began CPR while awaiting the arrival of EMS. Interview on [DATE] at 4:32 P.M. with Physician #400 revealed he had not been notified on [DATE] around 2:00 A.M. concerning Resident #1. Physician #400 stated Resident #1's vomiting and abnormal vitals were concerning and indicated the resident was on the edge, and he would have hoped the nursing staff would have called him. Physician #400 stated there should have been action beyond administering Tylenol. Review of the facility policy titled, Notification of Changes, dated [DATE], revealed the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies the resident's representative when there is a change requiring notification. Circumstances requiring notification include significant change in the resident's physical, mental, or psychological condition such as deterioration in health, mental, or psychological status. This may include life threatening conditions or clinical complications. This deficiency represents non-compliance investigated under Complaint Number OH00161084.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365674	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Arbors at Minerva		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - 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** 33019 Based on record review, emergency medical services (EMS) run report review, death certificate review, policy review, and interview, the facility failed to adequately monitor and provide timely and necessary care and treatment following a change in condition for Resident #1. This affected one (Resident#1) of three reviewed for change in condition. Actual Harm occurred on [DATE] at 1:48 A.M. when Resident #1 (who had previously been medicated for nausea/vomiting on [DATE] at 3:56 P.M. and 10:38 P.M.) vomited brown-colored emesis and had a decline in her baseline vital signs. The resident's blood pressure was ,d+[DATE] millimeters of Mercury (mm/Hg) (normal blood pressure is ,d+[DATE] mm/Hg), heart rate was 120 beats per minute (normal is ,d+[DATE]), temperature was 99.4 Fahrenheit (F), and oxygen saturation was 90% on room air (normal is 92% or higher on room air). Resident #1 complained of aching all over and was given Tylenol (analgesic and fever reducer) 325 milligrams (mg) two tablets. On [DATE] at 4:49 A.M. Resident #1 required cardiopulmonary resuscitation (CPR) following cardiac arrest. Licensed Practical Nurse (LPN) #200 went into the resident's room to reassess the effectiveness of the Tylenol administered earlier at 1:48 A.M., when Resident #1 complained that she did not feel right and was observed to have short, rapid respirations and was pale, cold and moist. The resident's blood pressure was unable to be read, oxygen saturation was 76% on room air, and temperature was 96.9 F. The physician was notified, and an order was given to send the resident to the emergency room (ER). Prior to the arrival of Emergency Medical Service (EMS) personnel, Resident #1's condition further declined, and CPR was initiated by nursing staff. Resident #1 required tracheal intubation (a flexible tube is inserted to maintain an open airway) and CPR was unsuccessfully administered for approximately 27 minutes in the facility. The resident was pronounced dead on [DATE] at 5:16 A.M. when the heart monitor revealed asystole (no pulse or electrical activity of the heart) following cardiac arrest. Findings include: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included paraplegia, morbid obesity, obstructive hydrocephalus, presence of cerebrospinal fluid drainage device, major depressive disorder, and abnormal posture. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition. The resident required physical assistance with activities of daily living. Review of the nursing progress note dated [DATE] at 11:30 A.M. revealed the resident received Zofran 4 mg (ordered [DATE]) by mouth for nausea and vomiting. The administration was listed as effective. Review of the nursing progress note dated [DATE] at 8:55 A.M. revealed Resident #1 had frequent episodes of emesis for the last three days and was unable to keep medications, fluids, and food down. The physician was notified. Review of the nursing progress note dated [DATE] at 3:34 P.M. revealed a physician order was given for promethazine 12.5 mg intramuscularly (IM) injection to be given every six hours as needed for nausea and vomiting. (continued on next page)

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	365674	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record, dated [DATE], revealed Resident #1 was administered promethazine 12.5 mg IM on [DATE] at 3:56 P.M. and 10:38 P.M. The medication administration was noted to be effective. Review of the nursing progress note dated [DATE] at 1:48 A.M. (authored by LPN #200) revealed brown colored emesis, varying from thick to watery. Vital signs: blood pressure ,d+[DATE], pulse 120, respirations 20, and oxygen saturation 90% on room air. Physician notified. (Subsequent interview with physician revealed he was not notified as documented in the progress note). Review of the nursing progress note dated [DATE] at 1:54 A.M. (authored by LPN #200) revealed acetaminophen 325 mg, two tablets, were given for pain. Review of the nursing progress note dated [DATE] at 5:15 A.M. (authored by LPN #200) revealed this nurse went into the resident's room to re-assess after Tylenol was given at 1:45 A.M. The resident stated she was not feeling right. This nurse observed the resident to have short, rapid respirations, her skin was cold and moist, pale in color. This nurse attempted to obtain another full set of vital signs; blood pressure was unable to be read, oxygen saturation was 76% on room air, and temperature was 96.2. Oxygen was applied via nasal cannula and the physician was notified. An order was given to send the resident to the ER. EMS was notified of the emergency need of transport. Second nurse arrived to assist this nurse (LPN #200), and the Director of Nursing (DON) was notified of the resident's rapid change in condition. This nurse grabbed the crash cart and automated external defibrillator (AED) from the wall. At 4:49 A.M. CPR was initiated by this nurse and second nurse. EMS arrive at 4:51 A.M. and stated they were unaware of need for an emergency and had to go back out to the ambulance to retrieve equipment. CPR was continued by nursing staff. Resident #1 was intubated. After 20 minutes, an emergency medical technician (EMT) told the nursing staff to stop CPR and called an ER doctor to get the time of death. The physician, DON, and power-of-attorney were notified. Review of the EMS Run Report revealed on [DATE] at 4:32 A.M. a call was received from the nursing facility for a low pulse oximetry and general illness. EMS arrived at the nursing facility at 4:51 A.M. Upon arrival, nursing staff informed EMS they were concerned Resident #1 was going to code. EMS personnel continued to the resident's room and observed nursing staff doing manual compressions to the resident who was in bed. Staff had their own AED applied and it was informed that compressions needed to be pushed harder. Paramedic #448 took over the compressions. Paramedic #448 noticed the resident's skin was cold on her upper extremities and chest. Staff reported the resident was talking before EMS arrived and coded one minute prior to EMS arrival. AED was advising no shock advised and the EMS cardiac monitor was showing asystole. The estimated time of cardiac arrest was 4:50 A.M. as witnessed by facility staff. CPR was discontinued at 5:16 A.M. EMS alerted hospital physician per protocol for the time of death. Review of Resident #1's Certificate of Death revealed the date of death was [DATE] at 5:16 A.M. The resident was [AGE] years old. The immediate cause of death was listed as sepsis syndrome with an approximate onset of 12 hours prior to death. The secondary cause of death was due to pyelonephritis, and the third cause of death was due to gastroenteritis. The Certificate of Death indicated no autopsy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arbors at Minerva		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on at [DATE] at 1:51 P.M. with LPN #200 revealed on [DATE], Resident #1 had complained of not feeling well and had vomited brown emesis. LPN #200 stated she administered Tylenol at this time. LPN#200 stated she went back to re-assess Resident #1 and the resident complained that she didn't feel well. LPN #200 stated she was unable to obtain a blood pressure reading and the resident's oxygen saturation was low, so she notified the physician, who ordered the resident to be sent to the ER. LPN #200 stated the resident continued to decline and coded about one minute prior to the arrival of EMS. LPN #200 stated she and LPN #290 began CPR while awaiting the arrival of EMS. Interview on at [DATE] at 2:35 P.M. with DON stated she had noticed during her investigation that almost three hours elapsed between LPN #200 giving Resident #1 Tylenol and reassessing the resident. The DON confirmed she would have expected LPN #200 to have re-assessed the resident sooner. Interview on [DATE] at 3:53 P.M. with CNA #30 revealed she was assigned to provide care to Resident #1 on [DATE]. CNA #30 stated Resident #1 complained of not feeling well and of aching all over. CNA #30 stated she reported this to the nurse and the nurse medicated the resident. CNA #30 stated she did not check back on the resident because she had to leave her shift at 2:30 A.M. due to an elevated body temperature and her assignment was given to CNA #40. Interview on [DATE] at 4:07 P.M. with CNA #40 revealed she was assigned to care for Resident #1 after CNA #30 left early and did not recall checking on the resident until after 4:00 A.M. CNA #40 stated Resident #1's call light went off and LPN #200 told her not to bother with it because she was going in to check on her. CNA #40 stated she went into Resident #1's room to assist LPN #200 and the corner of Resident #1's lips were blue, and the resident stated she didn't feel good. CNA #40 stated after another nurse came into the room, she left. CNA #40 stated she later went back into the room and the nurses were doing CPR on the resident. Interview on [DATE] at 4:32 P.M. with Physician #400 revealed he had not been notified on [DATE] around 2:00 A.M. concerning Resident #1. Physician #400 stated Resident #1's vomiting and abnormal vitals were concerning and indicated the patient was on the edge, and he would have hoped the nursing staff would have called him. Physician #400 stated there should have been action beyond administering Tylenol. Physician #400 stated his expectation would have been for staff to check on the resident after the vomiting incident before the time that they did. Review of the facility policy titled, Notification of Changes, dated [DATE], revealed the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies the resident's representative when there is a change requiring notification. Circumstances requiring notification include significant change in the resident's physical, mental, or psychological condition such as deterioration in health, mental, or psychological status. This may include life threatening conditions or clinical complications. This deficiency represents non-compliance investigated under Complaint Number OH00161084.