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	02/12/2026

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 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, observations and interviews, the facility failed to ensure transmission-based precautions were followed for Resident #2 and failed to ensure infection control practices were followed during catheter care for Resident #2 and #76. This affected one resident (Residents #2) out of five residents reviewed for transmission-based precautions and two (Residents #2 and #76) out of two residents reviewed for urinary catheters. The facility census was 74.Findings include: 1. Review of the medical record for Resident #14 revealed an admission date of 01/16/26 with diagnoses including sepsis, the presence of right artificial hip joint, need for assistance with personal care. Review of the Discharge summary dated [DATE] from the hospital for Resident #14 revealed she had diagnoses of sepsis and acute on chronic right hip periprosthetic methicillin-resistant staphylococcus aureus (MRSA) wound infection status post revision of total hip arthroplasty and debridement. Review of the care plan dated 01/16/26 for Resident #14 revealed she had an infection as evidenced by right hip revision with sepsis. Interventions included contact isolation precautions (gown and gloves). Review of the physician's orders for January and February 2026 for Resident #14 revealed she had a dressing ordered to her right hip daily. There were no orders noted for contact isolation. Review of the nursing progress notes for Resident #14 revealed on 01/16/26 at 10:30 P.M. she was admitted status post right hip debridement and there was skin impairment noted with a surgical incision to the right hip. On 01/17/26 at 8:53 A.M. nursing staff stated interoperative wound cultures from the hospital were positive for MRSA. She was to receive intravenous antibiotics until 02/17/26. On 01/26/26 at 10:53 A.M., nursing staff noted Resident #14's right hip wound was assessed and noted to have moderate drainage that was consistent with prior assessments. Review of the physician's progress note dated 01/21/26 by Medical Director (MD) #872 for Resident #14 revealed she was on prolonged intravenous antibiotic therapy through 02/17/26 for MRSA infection. Observation on 02/09/26 at 7:35 P.M. revealed Resident #14 did not have contact isolation signage on the door. Interview on 02/09/26 at 8:09 P.M. with Licensed Practical Nurse (LPN) #842 verified Resident #14 should have been on contact isolation because she was positive for MRSA. Interview on 02/10/26 at 1:50 P.M. with the Director of Nursing (DON) verified there were no contact isolation orders from 01/16/26 through 02/09/26. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Transmission-Based (Isolation) Precautions, dated 10/24/22, revealed contact precautions were intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. 2. Review of Resident #2's medical record revealed the resident was admitted on [DATE] with diagnoses including end stage renal disease with dialysis, obstructive and reflux uropathy and chronic gout. Review of Resident #2's care plans revealed an intervention dated 04/05/24 to use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #2's physician orders revealed an order dated 09/21/25 to use enhanced barriers while performing high-contact activity with the resident related to the catheter and dialysis; and an order dated 10/14/25 to change the suprapubic catheter every four weeks. Observation on 02/10/26 at 1:31 P.M. with Certified Nursing Assistant (CNA) #843 and CNA #839 revealed the staff members used a Hoyer mechanical lift to move the resident from the resident's wheelchair to the bed. CNA #843 and CNA #839 were observed to cleanse the suprapubic catheter with a washrag and soapy water. The staff members then cleaned the suprapubic catheter with clean water and dried the suprapubic with a clean towel. Both CNA #843 and CNA #839 were observed to implement latex gloves but not an isolation gown when providing suprapubic catheter care to the resident. Signage on the resident's door revealed the resident was placed in enhanced barrier precautions (EBP). Interview on 02/10/26 at 1:53 P.M. with CNA #843 and CNA #839 confirmed they did not implement isolation gowns during Resident #2's suprapubic catheter care as required. Review of the EBP policy revised 03/26/24 revealed it was the policy of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms. Even if a resident was not known to be infected or colonized with a multidrug-resistant organism, an order for EBP will be obtained for residents with wounds, indwelling medical devices such as central lines, urinary catheters, tracheostomy and ventilator tubes. Implementation of EBP may include but was not limited to gowns and gloves. 3.Review of the medical record for Resident #76 revealed an admission date of 06/12/25 with diagnoses that included malnutrition, chronic obstructive pulmonary disease (lung disease), obstructive uropathy (a blockage in the urinary system that can impede the ability to urinate), and heart failure. Review of the Minimum Data Set 3.0 (MDS) quarterly assessment dated [DATE] revealed Resident #76 was cognitively impaired, did not reject care, required maximal assistance for toileting hygiene, and had an indwelling urinary catheter (a tube inserted into the bladder to drain urine). Review of the physician orders revealed an order dated 06/26/25 for catheter care every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 02/12/26 at 9:17 A.M. of catheter care with CNA #868 revealed the following: located directly on the bedside table without a barrier was a resident cup, a television remote, a basin of water, a towel, a tube of barrier cream, skin cleanser, and what appeared to be two quarter sized areas of food residue; CNA #868 performed catheter; after catheter care was performed CNA # 868 performed perineal care of the external genitalia and after utilizing the skin cleanser placed it back down on the bedside table; CNA #868 then assisted Resident #76 to turn on their side and utilized the skin cleanser to clean the buttocks area and then placed the skin cleanser back down on the bedside table; CNA #868 then used the towel that was directly on the bedside table to dry Resident #76; CNA #868 then picked up the tube of barrier cream and applied it to the buttocks of Resident #76 and then placed the tube back on the bedside table; once care was completed the bed was moved into a low height and the urinary catheter bag was noted to be touching the floor; and after the soiled linens were gathered and CNA #868 washed their hands they left the room. An interview on 02/12/26 at 9:27 A.M. with CNA #868 revealed a barrier was not used because the bedside table was cleaned prior to the procedure. When CNA #868 was asked what disinfectant was used, they noted the standard blue cleanser with a spray top was the product used. When CNA #868 was asked to show which disinfectant was used on the bedside table, they produced a bottle of perineal skin cleanser. Perineal skin cleanser did not have disinfectant properties. At the time of the interview CNA #868 verified the above findings including the urinary catheter bag on the floor. Review of the facility policy titled Catheter Care Procedure-Urinary, dated 12/28/23 revealed catheter care would be provided to reduce bladder or kidney infections, and catheter care would be provided in accordance with current clinical standards.