STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365675	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Milford	5900 Meadowcreek Drive Milford, OH 45150

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, review of facility Self-Reported Incidents (SRIs), resident interview, staff interview, and review of the facility policy, the facility failed to ensure staff spoke to residents in a respectful manner. This affected one resident (Resident #61) of three residents reviewed for dignity and respect. The facility census was 69 residents.Findings include: Review of the medical record for Resident #61 revealed an admission date of 12/03/20 with diagnoses including spinal muscular atrophy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and type two diabetes. Review of the nurse progress note for Resident #61 dated 11/05/25 per Licensed Practical Nurse (LPN) #247 revealed a Certified Nursing Assistant (CNA) had not treated the resident in a respectful manner. Review of the Minimum Data Set (MDS) assessment for Resident #61 dated 01/08/26 revealed the resident was cognitively intact and required moderate to maximal assistance with staff for all activities of daily living (ADLs). Review of the facility SRI regarding Resident #61 dated 11/05/25 revealed the resident made an allegation of abuse per CNA #204. The facility's investigation determined abuse had not occurred. Interview on 03/09/26 at 8:31 A.M. with Resident #61 confirmed he didn't want CNA #204 to care for him anymore. Resident #61 stated he had complained to management about the way CNA #204 had treated him and he hadn't seen her since he reported his concerns. Interview on 03/11/26 at 1:40 P.M. with the Director of Nursing (DON) confirmed Resident #61 had complained about CNA #204 on 11/04/25 and the facility initiated a SRI and investigated the resident's concern. The DON stated the facility did not substantiate abuse, but did determine CNA #204 had spoken to Resident #61 in a disrespectful manner. The DON stated the facility gave CNA #204 a verbal warning and removed her from caring for Resident #61. Resident #61 had complained he asked CNA #204 if she was ignoring him and the aide responded that she was ignoring him. The DON confirmed CNA #204 admitted Resident #61's account of the incident was correct. This deficiency represents noncompliance investigated under Complaint Number 2796448 Complaint Number 2727533 and Complaint Number 2719129 and Complaint Number 2630244

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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(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. Based on medical record review, observation, review of Self-Reported Incidents (SRIs), staff interview, resident interview, and review of the facility policy, the facility failed to ensure residents were free from emotional/verbal abuse. This affected one (Resident #67) of three residents reviewed for abuse. The facility census was 69 residents. Findings include:Review of the medical record for Resident #67 revealed an admission date of 10/29/25 with diagnoses including generalized anxiety, major depressive disorder, and insomnia. Review of the Minimum Data Set (MDS) assessment for Resident #67 dated 02/05/26 revealed the resident was cognitively intact and used a motorized wheelchair for mobility. Review of the nurse progress note for Resident #67 dated 02/24/26 per Registered Nurse (RN) #219 revealed the resident requested to go to the hospital because she could taste soap in her mouth. Resident #67 reported she had used vaginal soap to eliminate odors after others had complained about her smell and posted about it on Facebook. RN #219 notified management and social services of Resident #67's statements. Observation of an online video titled Folgers Incest Commercial at https://youtu.be/fhfcWTZeP1k?si=0Ezm5vlOUgDAHx87 revealed the video depicts a coffee commercial in which a brother and a sister are drinking coffee together and are confronted by their parents who accuse them of having romantic feelings for one another and of having a sexual relationship. A family argument ensues and the siblings reveal they are having a sexual relationship and they intend to get married. Review of the facility SRI dated 02/24/26 revealed the facility investigated an allegation of emotional/verbal abuse towards Resident #67 per [NAME] #322 wherein the employee was friends on Facebook with the resident and sent her a video with Facebook which had themes involving incest-the YouTube video titled Folgers Incest Commercial. Resident #67 reported feeling emotionally upset by the video. The facility's investigation revealed [NAME] #322's actions were emotionally abusive and upsetting to Resident #67, and the facility substantiated abuse had occurred. The facility terminated [NAME] #322 and in-serviced all staff on the abuse policy and the social media policy. Interview on 03/10/26 at 2:35 P.M. with the Director of Nursing (DON) confirmed Resident #67 reported on 02/24/26 she was upset because she had heard [NAME] #332 had made a statement that the resident smelled like tuna. Resident #67 confirmed she was friends on the social media website Facebook with [NAME] #332. Resident #67 stated [NAME] #332sent her the YouTube video entitled Folgers Incest Commercial via Facebook. Resident #67 confirmed she found the video [NAME] #332 sent to be upsetting because of her personal history of sexual abuse as a child. The DON further confirmed the facility's investigation revealed [NAME] #332 admitted he was friends with Resident #67 on Facebook and he had sent her the video which the resident found to be emotionally triggering. Interview on 03/10/26 at 2:40 P.M. with the Administrator confirmed the facility's investigation revealed [NAME] #332 had admitted he was friends on Facebook with Resident #67 and he had sent the video titled Folger's Incest Commercial to the resident. Interview on 03/11/26 at 1:16 P.M. with Resident #67 confirmed she was Facebook friends with [NAME] #332, and he sent her a YouTube video titled Folgers Incest Commercial, and she found it upsetting and triggering because her father and brother had sexually abused her when she was a child. Interview on 03/12/26 at 9:36 A.M. with [NAME] #322 confirmed he had been Facebook friends with Resident #67 when he worked at the facility. [NAME] #332 stated he did send the YouTube video titled Folgers Incest Commercial via Facebook to Resident #67, because he thought it was funny. [NAME] #332 stated the video was from a comedy skit performed on the television show, Saturday Night Live. [NAME] #332 stated he was unaware of Resident #67's sexual abuse history and he did not intend to upset her by sending the video. [NAME] #332 stated Resident #67 told him she was upset because she had heard he made a statement about her having body odor. [NAME] #332 confirmed he never made a statement about Resident #67 having body odor and he told the resident he had not done so. Review of facility policy titled Social Media dated 04/04/17 revealed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the company respected the desire of employees to use social media for expression, but employees should refrain from trying to connect with residents and resident family members through the use of personal social media. This violation represents noncompliance investigated under Complaint Number 2795466 and Complaint Number 2630244 and Complaint Number 2615289 and Complaint Number 2611017.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, review of medication error logs, staff interview, observation, and review of the facility policy, the facility failed to ensure residents were free from significant medication errors. This affected two (Residents #69 and #42) of 17 sampled residents. The facility census was 69 residents. Findings include: 1.Review of the medical record for Resident #42 revealed an admission date of 12/02/24 with diagnosis including end stage renal disease, diabetes, and osteomyelitis. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 12/18/25 revealed the resident was cognitively intact. Review of the physician's orders for Resident #42 revealed an order dated 01/04/26 for Cubicin 700 milligrams (mg) per intravenous (IV) administration every other day for 34 days for treatment of an abdominal abscess. Review of the medication error log revealed the facility had a medication error involving Resident #42 on 01/28/26. Interview on 03/12/26 at 10:15 A.M. with the Director of Nursing (DON) on 01/27/26 staff administered Cubicin 500 mg per IV to Resident #42. The DON stated the nurse gave Resident #42 the wrong dose of Cubicin, a bag of IV medication that was intended for another resident. The nurse recognized the error on 01/28/26 at 8:44 A.M. after the bag of Cubicin had been completely administered to Resident #42 and she saw the other resident's name on the IV bag. Interview on 03/10/26 at 4:17 P.M. with Resident #42 confirmed the facility told her there had been a medication error in January 2026 in which she had not received the full dose of Cubicin. Review of the facility policy titled Medication Administration dated 01/17/23 revealed that licensed nurses were to identify resident by photo in the Medication Administration Record (MAR) and to compare the medication source with MAR to verify resident name, medication name, form, dose, route and time of administration. 2.Review of the medical record for Resident #69 revealed an admission date of 01/23/26 with diagnoses including acute and chronic respiratory failure, polyneuropathy, and anxiety disorder. Review of physician's orders for Resident #69 revealed an order dated 01/31/26 for routine oxycodone 10 mg every four hours for pain to be administered at 12:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M. Review of the MAR for Resident #69 dated 03/09/26 revealed the staff administered the resident's 8:00 A.M. dose of oxycodone at 11:18 A.M. Observation of medication administration on 03/12/26 at 10:05 A.M. to Resident #69 per Licensed Practical Nurse (LPN) #263 revealed the nurse administered the resident's 8:00 A.M. dose of oxycodone at 10:05 A.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/26 at 10:10 A.M. with LPN #263 confirmed he had administered Resident #69's 8:00 A.M. dose of oxycodone at 10:05 A.M. LPN #263 further confirmed it was permissible to administer medications one hour before or after the due time, but Resident #69's medication was late. Interview on 03/12/26 at 1:57 P.M. with Regional Nurse (RN) #316 confirmed staff administered Resident #69's oxycodone late on 03/09/26 and again on 03/12/26. Review of the facility policy titled Medication Administration dated 01/17/23 revealed medications should be administered within 60 minutes prior to or after scheduled time. This deficiency represents noncompliance investigated under Complaint Number 2729892 and Complaint Number 2709832 and Complaint Number 2616693.