| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Milford | 5900 Meadowcreek Drive<br>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.

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|---|---|
| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on medical record review and staff interview, the facility failed to ensure a resident's advance directive was fully completed and dated by the physician. This affected one (#65) of three residents reviewed for advanced directives. The facility census was 72.<br><br>Findings include:<br><br>Medical record review revealed Resident #65 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, end stage renal disease, cutaneous abscess of the abdominal wall, renal dialysis, essential primary hypertension, heart failure, dysphagia, and hyperlipidemia.<br><br>Review of the Minimum Data Set (MDS) assessment, dated 02/04/25, revealed Resident #65 had impaired cognition. Resident #65 was dependent on staff for medication administration, eating, dressing, bathing, and personal hygiene.<br><br>Review of the undated form titled, DNR Comfort Care, revealed Resident #65 was indicated to have a DNR Comfort Care (DNRCC) advanced directive selected; however, there was no selection made under the section titled Certification of DNR Comfort Care Status, with an indication that it was to be completed by a physician. The choices to select included Do-Not-Resuscitate-Order or Living Will (Declaration) and Qualifying Condition with instructions to check only one box, and neither were marked. Further review of the form revealed the physician signed the form but did not date it.<br><br>Review of the physician orders for Resident #65 dated 02/07/25 revealed an order for a DNRCC advanced directive.<br><br>Interview with Licensed Practical Nurse (LPN) #122 on 03/11/25 at 11:55 A.M. confirmed Resident #65's DNR Comfort Care form was signed by the physician; however, it was not dated. LPN #122 also confirmed the boxes were left blank related to Do Not Resuscitate Order and Living Will (Declaration) and Qualifying Condition. LPN #122 confirmed the physician's date was required. |

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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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on medical record review, review of a hospital record, staff interview, review of the facility investigation, and policy review, the facility failed to ensure the physician or nurse practitioner was notified timely of a significant change in condition for a resident (#70). This resulted in Immediate Jeopardy and serious life-threatening harm, injuries, and/or death when on [DATE] at 7:46 P.M., Resident #70 was found to have elevated blood glucose levels by a nurse and after notification to the nurse practitioner, additional insulin was ordered, which the resident refused. The nurse did not make notification to the nurse practitioner or physician of the resident's refusal of additional insulin and no additional checks of the resident's blood glucose level were attempted. Resident #70 was later found on the floor, was not answering questions, but was able to move all extremities, and the right side of the resident's face was slightly swollen. Furthermore, the nurse did not complete a neurological assessment of the resident, and no notifications were made to the physician or nurse practitioner of the resident's change in condition. Resident #70 was found later the next morning on [DATE] at 2:42 A.M. with bluish-colored skin tone, abdominal breathing, an extremely edematous head, and was not responding to verbal or physical stimuli. The lack of notification to the physician or nurse practitioner contributed to Resident #70's untimely death when the resident was taken to the emergency department, was found to have a further elevated blood glucose level, was diagnosed with acute encephalopathy, with multiple metabolic/infectious abnormalities, acute metabolic acidosis, and ultimately died . This affected one (#70) of three residents reviewed for change in condition and notification. The facility census was 72.<br><br>On [DATE] at 9:03 A.M., Regional Director of Operations #199 and Regional Director of Clinical Operations (RDCO) #595 were notified that Immediate Jeopardy began on [DATE] at 7:46 P.M. when Resident #70's blood glucose level measured 583 milligrams per deciliter (mg/dL) and previous Director of Nursing (DON) #395 notified the nurse practitioner of the elevated blood glucose level. The nurse practitioner ordered additional insulin which the resident refused, and previous DON #395 did not make notification to the nurse practitioner or physician of the resident's refusal of additional insulin and no additional checks of the resident's blood glucose level were attempted or documented in the medical record. Resident #70 was found on the floor on [DATE] at 2:42 A.M. and was not answering questions, but was able to move all extremities, and the right side of the resident's face was slightly swollen. Previous DON #395 did not complete a neurological assessment of the resident, and no notifications were made to the physician or nurse practitioner of the change in condition. On [DATE] at 7:15 A.M., Licensed Practical Nurse (LPN) #155 entered Resident #70's room to check the resident's blood glucose level and administer insulin and found Resident #70 in bed with bluish-colored skin tone, abdominal breathing, an extremely edematous head, and the resident was not responding to verbal or physical stimuli. A medical code was initiated by facility and emergency medical services (EMS) arrived at the facility and transported the resident to the hospital. At the hospital, Resident #70 was noted to have a blood glucose level greater than 784 mg/dL and had diagnoses of acute encephalopathy, with multiple metabolic/infectious abnormalities, and acute metabolic acidosis. Resident #70 ultimately died on [DATE].<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Immediate Jeopardy was removed on [DATE] at 4:00 P.M., when the facility sent Resident #70 to the ED for treatment following a change in condition, notification was made to the physician, the facility began an investigation, previous DON #395 was suspended, all residents were assessed for change in condition with all concerns addressed immediately, all staff members were educated, and all medical records were reviewed for change in condition and blood glucose levels with no concerns identified. The deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on [DATE] when the facility implemented the following corrective actions:<br><br>On [DATE] at 7:32 A.M., Resident #70 was sent to the ED with notification made to the physician.<br><br>On [DATE] beginning at 10:00 A.M., Previous Administrator #495 and Minimum Data Set (MDS) Nurse #146 reviewed the 24-hour report and self-identified a concern with Resident #70's refusal of an order for 16 units of insulin on [DATE] at 7:46 A.M. and failure to notify the physician/nurse practitioner during morning clinical meeting. This concluded at 12:00 P.M.<br><br>On [DATE] at 12:00 P.M., Previous Administrator #495 and RDCO #595 obtained statements and conducted interviews with LPN Unit Manager #600, Medication Technician #127, LPN #130, LPN #155, Respiratory Therapist (RT) #82, Certified Nurse Aide (CNA) #605, RT #124, CNA (#610), and previous DON #395. This concluded at 9:00 P.M.<br><br>On [DATE] at 2:30 P.M., RDCO #595 was notified by Previous Administrator #495 of the situation that involved Resident #70 and arrived at the facility at approximately 5:00 P.M. to assist with the investigation.<br><br>On [DATE] at 8:00 P.M., Registered Nurse (RN)/Staff Development Coordinator (SDC) #375 assessed all residents who had a recent fall and completed a neurological check. There were no residents found with a neurological change in condition.<br><br>On [DATE] at 9:00 P.M., LPN #116, LPN #146, RDCO #595, and LPN #600 assessed all residents for a change in condition. There were no residents found with a change in condition.<br><br>On [DATE] at 9:30 P.M., Previous Administrator #495 suspended previous DON #395 pending investigation for his failure to notify Nurse Practitioner (NP) #195 of Resident #70's refusal to be administered insulin as ordered by the nurse practitioner and subsequent change in condition. Previous DON #395 was terminated from employment on [DATE].<br><br>On [DATE], RN/SDC #375 provided all nurses, medication technicians, and CNAs with education related to fall assessment protocols, notification of physicians for resident change of condition, the importance of initiating treatment, the importance of rounding every two hours, the importance of obtaining neurological checks when it was suspected the resident had a head injury and/or was on blood thinners, and the importance of initiating the risk management application in the electronic medical record. All staff were educated by [DATE].<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 10:00 A.M., RDCO #595 and previous Administrator #495 notified facility Medical Director #995 of the incident and reviewed the policy and procedure for change in condition/notification of change. There were no revisions made to the policy. The root cause analysis identified failure to follow facility policy for notification to a physician by previous DON #395 as the primary cause for Resident #70's deteriorating change in condition.<br><br>On [DATE] at 10:00 A.M., a Quality Assurance and Performance Improvement (QAPI) meeting was held with previous Administrator #495, RDCO #595, and Medical Director #995. The policy for change in condition/physician notification was reviewed with no recommended revisions. The result of the facility's root cause analysis (RCA) was reviewed and the staff completed education was reviewed.<br><br>On [DATE] at 10:00 A.M., RN #122, LPN #155, and LPN #800 completed walking rounds for resident change in condition. One resident was found with a change in condition, and it was addressed immediately.<br><br>On [DATE] at 12:00 P.M., RDCO #595 reviewed all resident blood sugars to ensure notification of variances was made to the physician. There were no variances noted and was completed by 4:00 P.M.<br><br>Beginning on [DATE], RDCO #595/designee provided education on resident change in condition and notification to the physician/nurse practitioner to all newly hired nurses and CNAs.<br><br>Beginning on [DATE], RDCO #595/designee conducted a daily clinical meeting Monday through Friday, excluding holidays, to review residents with a change in condition and/or transfer to the hospital to ensure proper physician notification was made timely. The clinical meetings continue indefinitely with no concerns identified through the review period.<br><br>Beginning on [DATE], RDCO #595/designee monitored the results of the daily clinical meeting for residents with a change in condition and notification to the physician and submitted the findings to the QAPI committee for review and recommendations. This continued monthly with QAPI meetings held on [DATE] and [DATE] and then as needed. There were no concerns noted in the QAPI meeting minutes.<br><br>On [DATE], two (#1 and #19) additional resident medical records were reviewed for change in condition and notification of change with no concerns identified.<br><br>Interviews on [DATE] from 9:35 A.M. to 10:05 A.M. with RN #98, RN #122, CNA #96, CNA #80, CNA #119, CNA #127, CNA #99, CNA #105, and CNA #144 verified they received education from the facility regarding a resident change in condition or mental status change from the resident's baseline. CNAs interviewed verified they would immediately notify the nurse of the change in condition and nurses interviewed indicated the physician would be notified immediately. All staff members were able to recall the training and demonstrated proficiency of the education provided.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, tracheostomy, end-stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus Type I, hypertension, chronic obstructive pulmonary disease, and chronic viral Hepatitis C.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Minimum Data Set (MDS) Discharge-return not anticipated assessment dated [DATE] revealed Resident #70 had no cognitive deficit and was always continent of bowel and occasionally incontinent of urine. The resident required set up assistance for eating, oral and personal hygiene, toileting and transfers, moderate assistance for bathing, supervision for dressing, and was independent with bed mobility.<br><br>Review of a fall risk evaluation dated [DATE] revealed Resident #70 was a low risk for falls.<br><br>Review of physician orders revealed an order dated [DATE] for Resident #70 to be administered aspart insulin with niacinamide 100 units per milliliter per sliding scale subcutaneously (SQ) before meals related to diabetes mellitus Type I. The sliding scale was as follows: for blood glucose levels between zero (0) and 59 mg/dL, implement hypoglycemia protocol; for blood glucose levels between 60 and 150 mg/dL, give 0 units; for blood glucose levels between 151 and 200 mg/dL, give two (2) units; for blood glucose levels between 201 and 250 mg/dL, give four (4) units; for blood glucose levels between 251 and 300 mg/dL, give six (6) units; for blood glucose levels between 301 and 350 mg/dL, give eight (8) units; for blood glucose levels between 351 and 400 mg/dL, give 10 units; for blood glucose levels between 401 and 450, give 12 units; and for blood glucose levels greater than 451 mg/dL, notify the physician.<br><br>Review of Resident #70's [DATE] medication administration record (MAR) revealed Resident #70 refused aspart insulin with niacinamide 100 units per milliliter as per sliding scale SQ before meals related to diabetes mellitus type I doses on [DATE] at 11:00 A.M. when the blood glucose levels was 170 mg/dL and at 4:00 P.M. when blood sugar level was 400 mg/dL, on [DATE] at 7:00 A.M. when the blood glucose level was 465 mg/dL and at 4:00 P.M. when blood glucose level was 450 mg/dL, on [DATE] at 11:00 A.M. when the blood glucose level was 220 mg/dL, and on [DATE] at 11:00 A.M. when the blood glucose level was 587 mg/dL.<br><br>Review of a nursing progress note dated [DATE] at 7:46 P.M., written by LPN #150, revealed Resident #70's glucose reading was 583 mg/dL. The nurse practitioner was notified, and an order was received to administer 16 units of insulin which Resident #70 refused. The resident had a history of non-compliance with the medication regimen. The resident was educated on the risks, up to and including death, of refusing physician orders. The resident was alert and oriented and repeated back understanding of the risks.<br><br>Review of a nursing progress note dated [DATE] at 2:42 A.M., written by previous DON #395, revealed Resident #70 was found on the floor by a certified nurse aide. The resident was not answering questions but was able to move all extremities. The right side of the resident's face was slightly swollen. A neurologic examination was unable to be completed due to the resident not opening her eyes upon command.<br><br>Review of a nursing progress note dated [DATE] at 2:43 A.M., written by previous DON #395, revealed Resident #70 was assessed and the resident continued to move all extremities and her bilateral lower extremities which were over the side of the bed. The resident's respirations were easy yet unlabored and the resident continued to not follow commands.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a nursing progress note dated [DATE] at 7:15 A.M., written by LPN #155, revealed LPN #155 entered Resident #70's room to administer morning medications and obtain a fingerstick to check the resident's blood sugar and found the resident laying sideways across the bed with her legs dangling off the bed. The resident was noted with a bluish-colored skin tone and abdominal breathing. The resident's head was extremely edematous. The resident's cool air mist tubing was laying on her chest and not connected to the tracheostomy. A thick brown and blood-tinged sputum was noted in and around the tracheostomy. Resident #70 was unresponsive to verbal stimuli and sternal rub. LPN #155 called an emergency medical code at that time and two respiratory therapists immediately responded and initiated suctioning and providing breaths to the resident via a resuscitation (Ambu) bag. The resident's oxygen saturation was 94 percent (%) on the tracheostomy, the heart rate was 144 beats per minute, and the blood pressure could not be obtained. The respiratory therapists continued to provide respirations to Resident #70. At 7:24 A.M., emergency medical transport (EMT) personnel arrived on the scene and care was transitioned to them. At 7:27 A.M., EMT personnel remained on the scene providing first aid to the resident who continued to be unresponsive and with abdominal breathing. The resident's skin tone returned to a natural color. At 7:32 A.M., EMT personnel transported the resident from the facility to the hospital. A report was called to the receiving hospital emergency department (ED), and notifications were made to the physician and the resident's family. At 12:52 P.M., the resident was admitted to the hospital with a diagnosis of acute metabolic encephalopathy.<br><br>Review of hospital documents dated [DATE] at 1:09 P.M. revealed Resident #70 had a blood glucose level greater than 784 mg/dL and was admitted unresponsive on mechanical ventilation to the medical intensive care unit (MICU) with a concern for volume overload and flash pulmonary edema. The resident's temperature was 102.6 degrees Fahrenheit. The physician noted the resident was critically ill due to acute encephalopathy and comatose state and if untreated, there was a high risk of imminent or life-threatening deterioration of the resident's condition due to worsening hypoxic-ischemic brain injury, cerebral edema, seizures, brain compression and brain death. Further review of the hospital document revealed on [DATE] at 2:11 P.M., Resident #70 was also assigned a diagnosis of acute metabolic acidosis.<br><br>Review of a nursing progress note dated [DATE] revealed the family reported Resident #70 expired in the hospital today.<br><br>Interview on [DATE] at 12:41 P.M. with Registered Nurse (RN) #390 verified there was no documentation that indicated neurological checks were performed on Resident #70 from the time she was found on the floor at [DATE] at 2:42 A.M. until she was transported to the hospital on [DATE] at 7:32 A.M. by EMT personnel or that the physician was notified of the resident's change in condition until transport to the hospital on [DATE] at 7:32 A.M.<br><br>Telephone interview on [DATE] at 1:12 P.M. with previous DON #395 verified neurological checks were not performed on Resident #70 after finding her on the floor on [DATE] at 2:42 A.M. through the time she was transported to the hospital on [DATE] at 7:32 A.M. Previous DON #395 also verified neither the physician, physician extender, nor family were notified of the resident's change in condition until after the resident was transported to the hospital. He was unable to provide rationale as to why neither neurological checks were obtained nor why the physician and family were not notified.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Telephone interview on [DATE] at 8:32 A.M. with Nurse Practitioner (NP) #195 verified it was the expectation for the facility to make immediate notification to the physician or physician extender for any resident who was experiencing or who had experienced a change in condition. NP #195 verified the facility did not make notification for Resident #70's change in condition until the resident was transported to the hospital on [DATE] at 7:32 A.M. NP #195 stated she should have been called immediately after the resident was found on the floor on [DATE] at 2:42 A.M., especially when it was noted the resident had swelling noted to the face and was on an anticoagulant medication.<br><br>Interview on [DATE] at 8:40 A.M. with the current DON revealed the findings of the facility's investigation were inconclusive as to how Resident #70 became to be on the floor in the early morning hours of [DATE]. The DON stated Resident #70 had a blanket on the floor and her oxygen tubing remained connected to her tracheostomy. The DON stated it was a strong possibility the resident placed herself on the floor and laid down. The DON did verify neurological checks were not completed on Resident #70 nor was the physician notified of the resident's change in condition until after transport to the hospital on [DATE] at 7:32 A.M.<br><br>Interview on [DATE] at 11:55 P.M. with NP #195 verified Resident #70 had a history of erratic blood glucose levels and stated the resident was afraid of being administered greater than 8 units of insulin for fear of it stacking up due to her diagnosis of type I diabetes mellitus. NP #195 verified the facility, and specifically previous DON #395, should have notified her immediately of the resident refusing the order for the 16 units of insulin on [DATE] at 7:46 P.M. and the resident should have been reassessed between [DATE] at 7:46 P. M. and [DATE] at 2:42 A.M. with an update provided. NP #195 also verified she would have definitely ordered the resident be sent to the hospital on [DATE] at 2:42 A.M. had she been notified by previous DON #395.<br><br>Review of the policy titled, Notification of Changes, revised [DATE], revealed the purpose of this policy was to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, resident's representative when there was a change requiring notification. Circumstances requiring notification include a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status that may include life-threatening conditions or clinical complications. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on medical record review, review of a hospital record, staff interview, review of the facility investigation, and policy review, the facility failed to ensure a resident (#70) was free from neglect when the facility failed to provide appropriate and timely assessment, treatment, service, and notification to the physician or nurse practitioner. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries, and/or death when on [DATE] at 7:46 P.M., Resident #70 was found to have elevated blood glucose levels by a nurse and after notification to the nurse practitioner, additional insulin was ordered, which the resident refused. The nurse did not make notification to the nurse practitioner or physician of the resident's refusal of additional insulin and no additional checks of the resident's blood glucose level were attempted. Resident #70 was later found on the floor, was not answering questions, but was able to move all extremities, and the right side of the resident's face was slightly swollen. Furthermore, the nurse did not complete a neurological assessment of the resident, and no notifications were made to the physician or nurse practitioner of the resident's change in condition. Resident #70 was found later the next morning on [DATE] at 2:42 A.M. with bluish-colored skin tone, abdominal breathing, an extremely edematous head, and was not responding to verbal or physical stimuli. The lack of timely assessments, treatments, services, and notification to the physician or nurse practitioner contributed to Resident #70's untimely death when the resident was taken to the emergency department, was found to have a further elevated blood glucose level, was diagnoses with acute encephalopathy, with multiple metabolic/infectious abnormalities, acute metabolic acidosis, and ultimately died . This affected one (#70) of three residents reviewed for abuse and neglect. The facility census was 72.<br><br>On [DATE] at 9:03 A.M., Regional Director of Operations #199 and Regional Director of Clinical Operations (RDCO) #595 were notified that Immediate Jeopardy began on [DATE] at 7:46 P.M. when Resident #70's blood glucose level measured 583 milligrams per deciliter (mg/dL) and previous Director of Nursing (DON) #395 notified the nurse practitioner of the elevated blood glucose level. The nurse practitioner ordered additional insulin which the resident refused, and previous DON #395 did not make notification to the nurse practitioner or physician of the resident's refusal of additional insulin and no additional checks of the resident's blood glucose level were attempted or documented in the medical record. Resident #70 was found on the floor on [DATE] at 2:42 A.M. and was not answering questions, but was able to move all extremities, and the right side of the resident's face was slightly swollen. Previous DON #395 did not complete a neurological assessment of the resident, and no notifications were made to the physician or nurse practitioner of the change in condition. On [DATE] at 7:15 A.M., Licensed Practical Nurse (LPN) #155 entered Resident #70's room to check the resident's blood glucose level and administer insulin and found Resident #70 in bed with bluish-colored skin tone, abdominal breathing, an extremely edematous head, and the resident was not responding to verbal or physical stimuli. A medical code was initiated by facility and emergency medical services (EMS) arrived at the facility and transported the resident to the hospital. At the hospital, Resident #70 was noted to have a blood glucose level greater than 784 mg/dL and had diagnoses of acute encephalopathy, with multiple metabolic/infectious abnormalities, and acute metabolic acidosis. Resident #70 ultimately died on [DATE].<br><br>(continued on next page) |

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| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

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| Arbors at Milford | 5900 Meadowcreek Drive<br>Milford, OH 45150 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Immediate Jeopardy was removed on [DATE] at 4:00 P.M., when the facility sent Resident #70 to the ED for treatment following a change in condition, notification was made to the physician, the facility began an investigation, previous DON #395 was suspended, all residents were assessed for change in condition with all concerns addressed immediately, all staff members were educated, and all medical records were reviewed for change in condition and blood glucose levels with no concerns identified. The deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on [DATE] when the facility implemented the following corrective actions:<br><br>On [DATE] at 7:32 A.M., Resident #70 was sent to the ED with notification made to the physician.<br><br>On [DATE] beginning at 10:00 A.M., Previous Administrator #495 and Minimum Data Set (MDS) Nurse #146 reviewed the 24-hour report and self-identified a concern with Resident #70's refusal of an order for 16 units of insulin on [DATE] at 7:46 A.M. and failure to notify the physician/nurse practitioner during morning clinical meeting. This concluded at 12:00 P.M.<br><br>On [DATE] at 12:00 P.M., Previous Administrator #495 and RDCO #595 obtained statements and conducted interviews with LPN Unit Manager #600, Medication Technician #127, LPN #130, LPN #155, Respiratory Therapist (RT) #82, Certified Nurse Aide (CNA) #605, RT #124, CNA (#610), and previous DON #395. This concluded at 9:00 P.M.<br><br>On [DATE] at 2:30 P.M., RDCO #595 was notified by Previous Administrator #495 of the situation that involved Resident #70 and arrived at the facility at approximately 5:00 P.M. to assist with the investigation.<br><br>On [DATE] at 8:00 P.M., Registered Nurse (RN)/Staff Development Coordinator (SDC) #375 assessed all residents who had a recent fall and completed a neurological check. There were no residents found with a neurological change in condition.<br><br>On [DATE] at 9:00 P.M., LPN #116, LPN #146, RDCO #595, and LPN #600 assessed all residents for a change in condition. There were no residents found with a change in condition.<br><br>On [DATE] at 9:30 P.M., Previous Administrator #495 suspended previous DON #395 pending investigation for his failure to notify Nurse Practitioner (NP) #195 of Resident #70's refusal to be administered insulin as ordered by the nurse practitioner and subsequent change in condition. Previous DON #395 was terminated from employment on [DATE].<br><br>On [DATE], RN/SDC #375 provided all nurses, medication technicians, and CNAs with education related to fall assessment protocols, notification of physicians for resident change of condition, the importance of initiating treatment, the importance of rounding every two hours, the importance of obtaining neurological checks when it was suspected the resident had a head injury and/or was on blood thinners, and the importance of initiating the risk management application in the electronic medical record. All staff were educated by [DATE].<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 10:00 A.M., RDCO #595 and previous Administrator #495 notified facility Medical Director #995 of the incident and reviewed the policy and procedure for change in condition/notification of change. There were no revisions made to the policy. The root cause analysis identified failure to follow facility policy for notification to a physician by previous DON #395 as the primary cause for Resident #70's deteriorating change in condition.<br><br>On [DATE] at 10:00 A.M., a Quality Assurance and Performance Improvement (QAPI) meeting was held with previous Administrator #495, RDCO #595, and Medical Director #995. The policy for change in condition/physician notification was reviewed with no recommended revisions. The result of the facility's root cause analysis (RCA) was reviewed and the staff completed education was reviewed.<br><br>On [DATE] at 10:00 A.M., RN #122, LPN #155, and LPN #800 completed walking rounds for resident change in condition. One resident was found with a change in condition, and it was addressed immediately.<br><br>On [DATE] at 12:00 P.M., RDCO #595 reviewed all resident blood sugars to ensure notification of variances was made to the physician. There were no variances noted and was completed by 4:00 P.M.<br><br>Beginning on [DATE], RDCO #595/designee provided education on resident change in condition and notification to the physician/nurse practitioner to all newly hired nurses and CNAs.<br><br>Beginning on [DATE], RDCO #595/designee conducted a daily clinical meeting Monday through Friday, excluding holidays, to review residents with a change in condition and/or transfer to the hospital to ensure proper physician notification was made timely. The clinical meetings continue indefinitely with no concerns identified through the review period.<br><br>Beginning on [DATE], RDCO #595/designee monitored the results of the daily clinical meeting for residents with a change in condition and notification to the physician and submitted the findings to the QAPI committee for review and recommendations. This continued monthly with QAPI meetings held on [DATE] and [DATE] and then as needed. There were no concerns noted in the QAPI meeting minutes.<br><br>On [DATE], two (#1 and #19) additional resident medical records were reviewed for abuse and neglect with no concerns identified.<br><br>Interviews on [DATE] from 9:35 A.M. to 10:05 A.M. with RN #98, RN #122, CNA #96, CNA #80, CNA #119, CNA #127, CNA #99, CNA #105, and CNA #144 verified they received education from the facility regarding a resident change in condition or mental status change from the resident's baseline. CNAs interviewed verified they would immediately notify the nurse of the change in condition and nurses interviewed indicated the physician would be notified immediately. All staff members were able to recall the training and demonstrated proficiency of the education provided.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, tracheostomy, end-stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus Type I, hypertension, chronic obstructive pulmonary disease, and chronic viral Hepatitis C.<br><br>(continued on next page) |

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| Arbors at Milford | 5900 Meadowcreek Drive<br>Milford, OH 45150 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Minimum Data Set (MDS) Discharge-return not anticipated assessment dated [DATE] revealed Resident #70 had no cognitive deficit and was always continent of bowel and occasionally incontinent of urine. The resident required set up assistance for eating, oral and personal hygiene, toileting and transfers, moderate assistance for bathing, supervision for dressing, and was independent with bed mobility.<br><br>Review of physician orders revealed Resident #70 had an order dated [DATE] to be administered the anticoagulant medication Eliquis 2.5 milligrams (mg) by mouth with instructions to give one tablet every morning and at bedtime.<br><br>Review of a fall risk evaluation dated [DATE] revealed Resident #70 was a low risk for falls.<br><br>Review of physician orders revealed an order dated [DATE] for Resident #70 to be administered aspart insulin with niacinamide 100 units per milliliter per sliding scale subcutaneously (SQ) before meals related to diabetes mellitus Type I. The sliding scale was as follows: for blood glucose levels between zero (0) and 59 mg/dL, implement hypoglycemia protocol; for blood glucose levels between 60 and 150 mg/dL, give 0 units; for blood glucose levels between 151 and 200 mg/dL, give two (2) units; for blood glucose levels between 201 and 250 mg/dL, give four (4) units; for blood glucose levels between 251 and 300 mg/dL, give six (6) units; for blood glucose levels between 301 and 350 mg/dL, give eight (8) units; for blood glucose levels between 351 and 400 mg/dL, give 10 units; for blood glucose levels between 401 and 450, give 12 units; and for blood glucose levels greater than 451 mg/dL, notify the physician.<br><br>Review of Resident #70's [DATE] medication administration record (MAR) revealed Resident #70 refused aspart insulin with niacinamide 100 units per milliliter as per sliding scale SQ before meals related to diabetes mellitus type I doses on [DATE] at 11:00 A.M. when the blood glucose levels was 170 mg/dL and at 4:00 P.M. when blood sugar level was 400 mg/dL, on [DATE] at 7:00 A.M. when the blood glucose level was 465 mg/dL and at 4:00 P.M. when blood glucose level was 450 mg/dL, on [DATE] at 11:00 A.M. when the blood glucose level was 220 mg/dL, and on [DATE] at 11:00 A.M. when the blood glucose level was 587 mg/dL.<br><br>Review of a nursing progress note dated [DATE] at 7:46 P.M., written by Licensed Practical Nurse (LPN) #150, revealed Resident #70's glucose reading was 583 mg/dL. The nurse practitioner was notified, and an order was received to administer 16 units of insulin which Resident #70 refused. The resident had a history of non-compliance with the medication regimen. The resident was educated on the risks, up to and including death, of refusing physician orders. The resident was alert and oriented and repeated back understanding of the risks.<br><br>Review of a nursing progress note dated [DATE] at 2:42 A.M., written by previous DON #395, revealed Resident #70 was found on the floor by a certified nurse aide. The resident was not answering questions but was able to move all extremities. The right side of the resident's face was slightly swollen. A neurologic examination was unable to be completed due to the resident not opening her eyes upon command.<br><br>Review of a nursing progress note dated [DATE] at 2:43 A.M., written by previous DON #395, revealed Resident #70 was assessed and the resident continued to move all extremities and her bilateral lower extremities which were over the side of the bed. The resident's respirations were easy yet unlabored and the resident continued to not follow commands.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a nursing progress note dated [DATE] at 7:15 A.M., written by LPN #155, revealed LPN #155 entered Resident #70's room to administer morning medications and obtain a fingerstick to check the resident's blood sugar and found the resident laying sideways across the bed with her legs dangling off the bed. The resident was noted with a bluish-colored skin tone and abdominal breathing. The resident's head was extremely edematous. The resident's cool air mist tubing was laying on her chest and not connected to the tracheostomy. A thick brown and blood-tinged sputum was noted in and around the tracheostomy. Resident #70 was unresponsive to verbal stimuli and sternal rub. LPN #155 called an emergency medical code at that time and two respiratory therapists immediately responded and initiated suctioning and providing breaths to the resident via a resuscitation (Ambu) bag. The resident's oxygen saturation was 94 percent (%) on the tracheostomy, the heart rate was 144 beats per minute, and the blood pressure could not be obtained. The respiratory therapists continued to provide respirations to Resident #70. At 7:24 A.M., emergency medical transport (EMT) personnel arrived on the scene and care was transitioned to them. At 7:27 A.M., EMT personnel remained on the scene providing first aid to the resident who continued to be unresponsive and with abdominal breathing. The resident's skin tone returned to a natural color. At 7:32 A.M., EMT personnel transported the resident from the facility to the hospital. A report was called to the receiving hospital emergency department (ED) and notifications were made to the physician and the resident's family. At 12:52 P.M., the resident was admitted to the hospital with a diagnosis of acute metabolic encephalopathy.<br><br>Review of hospital documents dated [DATE] at 1:09 P.M. revealed Resident #70 had a blood glucose level greater than 784 mg/dL and was admitted unresponsive on mechanical ventilation to the medical intensive care unit (MICU) with a concern for volume overload and flash pulmonary edema. The resident's temperature was 102.6 degrees Fahrenheit. The physician noted the resident was critically ill due to acute encephalopathy and comatose state and if untreated, there was a high risk of imminent or life-threatening deterioration of the resident's condition due to worsening hypoxic-ischemic brain injury, cerebral edema, seizures, brain compression and brain death. Further review of the hospital document revealed on [DATE] at 2:11 P.M., Resident #70 was also assigned a diagnosis of acute metabolic acidosis.<br><br>Review of a nursing progress note dated [DATE] revealed the family reported Resident #70 expired in the hospital today.<br><br>Interview on [DATE] at 12:41 P.M. with RN #390 verified there was no documentation that indicated neurological checks were performed on Resident #70 from the time she was found on the floor at [DATE] at 2:42 A.M. until she was transported to the hospital on [DATE] at 7:32 A.M. by EMT personnel or that the physician was notified of the resident's change in condition until transport to the hospital on [DATE] at 7:32 A. M.<br><br>Telephone interview on [DATE] at 1:12 P.M. with previous DON #395 verified neurological checks were not performed on Resident #70 after finding her on the floor on [DATE] at 2:42 A.M. through the time she was transported to the hospital on [DATE] at 7:32 A.M. Previous DON #395 also verified neither the physician, physician extender, nor family were notified of the resident's change in condition until after the resident was transported to the hospital. He was unable to provide rationale as to why neither neurological checks were obtained nor why the physician and family were not notified.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Telephone interview on [DATE] at 8:32 A.M. with NP #195 verified it was the expectation for the facility to make immediate notification to the physician or physician extender for any resident who was experiencing or who had experienced a change in condition. NP #195 verified the facility did not make notification for Resident #70's change in condition until the resident was transported to the hospital on [DATE] at 7:32 A.M. NP #195 stated she should have been called immediately after the resident was found on the floor on [DATE] at 2:42 A.M., especially when it was noted the resident had swelling noted to the face and was on an anticoagulant medication.<br><br>Interview on [DATE] at 8:40 A.M. with the current DON revealed the findings of the facility's investigation were inconclusive as to how Resident #70 became to be on the floor in the early morning hours of [DATE]. The DON stated Resident #70 had a blanket on the floor and her oxygen tubing remained connected to her tracheostomy. The DON stated it was a strong possibility the resident placed herself on the floor and laid down. The DON did verify neurological checks were not completed on Resident #70 nor was the physician notified of the resident's change in condition until after transport to the hospital on [DATE] at 7:32 A.M.<br><br>Interview on [DATE] at 11:55 P.M. with NP #195 verified Resident #70 had a history of erratic blood glucose levels and stated the resident was afraid of being administered greater than 8 units of insulin for fear of it stacking up due to her diagnosis of type I diabetes mellitus. NP #195 verified the facility, and specifically previous DON #395, should have notified her immediately of the resident refusing the order for the 16 units of insulin on [DATE] at 7:46 P.M. and the resident should have been reassessed between [DATE] at 7:46 P. M. and [DATE] at 2:42 A.M. with an update provided. NP #195 also verified she would have definitely ordered the resident be sent to the hospital on [DATE] at 2:42 A.M. had she been notified by previous DON #395.<br><br>Review of the policy titled, Abuse, Neglect, and Exploitation, revised [DATE], revealed it was the policy for the facility to provide protections for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Neglect was defined in the policy as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will develop and implement written policies and procedures that: prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00162132. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on medical record review, hospital documentation, personnel file review, review of self-reported incidents (SRIs), staff interview, and policy review, the facility failed to report allegations of neglect to the Administrator and State Survey Agency. This affected four (#59, #70, #122, and #123) of five residents reviewed for neglect. The facility census was 72.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, tracheostomy, end-stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus Type I, hypertension, chronic obstructive pulmonary disease, and chronic viral Hepatitis C.<br><br>Review of the Minimum Data Set (MDS) Discharge-return not anticipated assessment dated [DATE] revealed Resident #70 had no cognitive deficit and was always continent of bowel and occasionally incontinent of urine. The resident required set up assistance for eating, oral and personal hygiene, toileting and transfers, moderate assistance for bathing, supervision for dressing, and was independent with bed mobility.<br><br>Review of physician orders revealed Resident #70 had an order dated [DATE] to be administered the anticoagulant medication Eliquis 2.5 milligrams (mg) by mouth with instructions to give one tablet every morning and at bedtime.<br><br>Review of a fall risk evaluation dated [DATE] revealed Resident #70 was a low risk for falls.<br><br>Review of physician orders revealed an order dated [DATE] for Resident #70 to be administered aspart insulin with niacinamide 100 units per milliliter per sliding scale subcutaneously (SQ) before meals related to diabetes mellitus Type I. The sliding scale was as follows: for blood glucose levels between zero (0) and 59 milligrams per deciliter (mg/dL), implement hypoglycemia protocol; for blood glucose levels between 60 and 150 mg/dL, give 0 units; for blood glucose levels between 151 and 200 mg/dL, give two (2) units; for blood glucose levels between 201 and 250 mg/dL, give four (4) units; for blood glucose levels between 251 and 300 mg/dL, give six (6) units; for blood glucose levels between 301 and 350 mg/dL, give eight (8) units; for blood glucose levels between 351 and 400 mg/dL, give 10 units; for blood glucose levels between 401 and 450, give 12 units; and for blood glucose levels greater than 451 mg/dL, notify the physician.<br><br>Review of Resident #70's [DATE] medication administration record (MAR) revealed Resident #70 refused aspart insulin with niacinamide 100 units per milliliter as per sliding scale SQ before meals related to diabetes mellitus type I doses on [DATE] at 11:00 A.M. when the blood glucose levels was 170 mg/dL and at 4:00 P.M. when blood sugar level was 400 mg/dL, on [DATE] at 7:00 A.M. when the blood glucose level was 465 mg/dL and at 4:00 P.M. when blood glucose level was 450 mg/dL, on [DATE] at 11:00 A.M. when the blood glucose level was 220 mg/dL, and on [DATE] at 11:00 A.M. when the blood glucose level was 587 mg/dL.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a nursing progress note dated [DATE] at 7:46 P.M., written by Licensed Practical Nurse (LPN) #150, revealed Resident #70's glucose reading was 583 mg/dL. The nurse practitioner was notified, and an order was received to administer 16 units of insulin which Resident #70 refused. The resident had a history of non-compliance with the medication regimen. The resident was educated on the risks, up to and including death, of refusing physician orders. The resident was alert and oriented and repeated back understanding of the risks.<br><br>Review of a nursing progress note dated [DATE] at 2:42 A.M., written by previous Director of Nursing (DON) #395, revealed Resident #70 was found on the floor by a certified nurse aide. The resident was not answering questions but was able to move all extremities. The right side of the resident's face was slightly swollen. A neurologic examination was unable to be completed due to the resident not opening her eyes upon command.<br><br>Review of a nursing progress note dated [DATE] at 2:43 A.M., written by previous DON #395, revealed Resident #70 was assessed and the resident continued to move all extremities and her bilateral lower extremities which were over the side of the bed. The resident's respirations were easy yet unlabored and the resident continued to not follow commands.<br><br>Review of a nursing progress note dated [DATE] at 7:15 A.M., written by Licensed Practical Nurse (LPN) #155, revealed LPN #155 entered Resident #70's room to administer morning medications and obtain a fingerstick to check the resident's blood sugar and found the resident laying sideways across the bed with her legs dangling off the bed. The resident was noted with a bluish-colored skin tone and abdominal breathing. The resident's head was extremely edematous. The resident's cool air mist tubing was laying on her chest and not connected to the tracheostomy. A thick brown and blood-tinged sputum was noted in and around the tracheostomy. Resident #70 was unresponsive to verbal stimuli and sternal rub. LPN #155 called an emergency medical code at that time and two respiratory therapists immediately responded and initiated suctioning and providing breaths to the resident via a resuscitation (Ambu) bag. The resident's oxygen saturation was 94 percent (%) on the tracheostomy, the heart rate was 144 beats per minute, and the blood pressure could not be obtained. The respiratory therapists continued to provide respirations to Resident #70. At 7:24 A.M., emergency medical transport (EMT) personnel arrived on the scene and care was transitioned to them. At 7:27 A.M., EMT personnel remained on the scene providing first aid to the resident who continued to be unresponsive and with abdominal breathing. The resident's skin tone returned to a natural color. At 7:32 A.M., EMT personnel transported the resident from the facility to the hospital. A report was called to the receiving hospital emergency department (ED) and notifications were made to the physician and the resident's family. At 12:52 P.M., the resident was admitted to the hospital with a diagnosis of acute metabolic encephalopathy.<br><br>Review of hospital documents dated [DATE] at 1:09 P.M. revealed Resident #70 had a blood glucose level greater than 784 mg/dL and was admitted unresponsive on mechanical ventilation to the medical intensive care unit (MICU) with a concern for volume overload and flash pulmonary edema. The resident's temperature was 102.6 degrees Fahrenheit. The physician noted the resident was critically ill due to acute encephalopathy and comatose state and if untreated, there was a high risk of imminent or life-threatening deterioration of the resident's condition due to worsening hypoxic-ischemic brain injury, cerebral edema, seizures, brain compression and brain death. Further review of the hospital document revealed on [DATE] at 2:11 P.M., Resident #70 was also assigned a diagnosis of acute metabolic acidosis.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Milford | 5900 Meadowcreek Drive<br>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) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a nursing progress note dated [DATE] revealed the family reported Resident #70 expired in the hospital today.<br><br>Interview on [DATE] at 12:41 P.M. with Registered Nurse (RN) #390 verified there was no documentation that indicated neurological checks were performed on Resident #70 from the time she was found on the floor at [DATE] at 2:42 A.M. until she was transported to the hospital on [DATE] at 7:32 A.M. by EMT personnel or that the physician was notified of the resident's change in condition until transport to the hospital on [DATE] at 7:32 A.M.<br><br>Telephone interview on [DATE] at 1:12 P.M. with previous DON #395 verified neurological checks were not performed on Resident #70 after finding her on the floor on [DATE] at 2:42 A.M. through the time she was transported to the hospital on [DATE] at 7:32 A.M. Previous DON #395 also verified neither the physician, physician extender, nor family were notified of the resident's change in condition until after the resident was transported to the hospital. He was unable to provide rationale as to why neither neurological checks were obtained nor why the physician and family were not notified.<br><br>Telephone interview on [DATE] at 8:32 A.M. with Nurse Practitioner (NP) #195 verified it was the expectation for the facility to make immediate notification to the physician or physician extender for any resident who was experiencing or who had experienced a change in condition. NP #195 verified the facility did not make notification for Resident #70's change in condition until the resident was transported to the hospital on [DATE] at 7:32 A.M. NP #195 stated she should have been called immediately after the resident was found on the floor on [DATE] at 2:42 A.M., especially when it was noted the resident had swelling noted to the face and was on an anticoagulant medication.<br><br>Interview on [DATE] at 8:40 A.M. with the current DON revealed the findings of the facility's investigation were inconclusive as to how Resident #70 became to be on the floor in the early morning hours of [DATE]. The DON stated Resident #70 had a blanket on the floor and her oxygen tubing remained connected to her tracheostomy. The DON stated it was a strong possibility the resident placed herself on the floor and laid down. The DON did verify neurological checks were not completed on Resident #70 nor was the physician notified of the resident's change in condition until after transport to the hospital on [DATE] at 7:32 A.M.<br><br>Interview on [DATE] at 11:55 P.M. with NP #195 verified Resident #70 had a history of erratic blood glucose levels and stated the resident was afraid of being administered greater than 8 units of insulin for fear of it stacking up due to her diagnosis of type I diabetes mellitus. NP #195 verified the facility, and specifically previous DON #395, should have notified her immediately of the resident refusing the order for the 16 units of insulin on [DATE] at 7:46 P.M. and the resident should have been reassessed between [DATE] at 7:46 P. M. and [DATE] at 2:42 A.M. with an update provided. NP #195 also verified she would have definitely ordered the resident be sent to the hospital on [DATE] at 2:42 A.M. had she been notified by previous DON #395.<br><br>Review of facility self-reported incidents from [DATE] revealed no evidence the facility notified the State Survey Agency of a situation of neglect involving Resident #70's lack of assessment, treatment, and notification of change to the physician or nurse practitioner.<br><br>Interview on [DATE] at 6:46 P.M. with Regional Director of Clinical Operations (RDCO) #199 verified the facility did not report the situation of neglect involving Resident #70 to the State Survey Agency.<br><br>(continued on next page) |

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| Arbors at Milford | 5900 Meadowcreek Drive<br>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.

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Medical record review for Resident#59 revealed he admitted to the facility on [DATE]. Diagnoses included orthostatic hypertension, cerebral vascular accident, depression, hypertension, hyperlipidemia, diabetes mellitus (DM), and respiratory failure.<br><br>Review of the MDS assessment for Resident #59, dated [DATE], revealed he had impaired cognition. Resident #59 was dependent on staff for oral hygiene, medication administration, toilet use, personal hygiene, bathing, dressing, transfers, and bed mobility. Resident #59 required a tube feed for nutrition and had an invasive mechanical ventilator.<br><br>3. Medical record review for Resident #122 revealed he was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure, osteomyelitis, dependence on respiratory ventilator, major depressive disorder, atrial fibrillation, acute kidney failure, dysphasia, and anxiety disorder.<br><br>Review of the MDS assessment, dated [DATE], revealed Resident #122 was cognitively intact. Further review of the MDS assessment confirmed Resident #122 was dependent on staff for medication administration, toilet use, lower body dressing, and putting on shoes. Resident #122 required assistance with meals and oral hygiene. He required maximum assistance with showering and required an invasive mechanical ventilator.<br><br>4. Medical record review for Resident #123 revealed he was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, major depressive disorder, essential primary hypertension, pulmonary embolism, cerebral infarction, and DM.<br><br>Review of the MDS assessment, dated [DATE], revealed Resident #123 had impaired cognition. Resident #123 was dependent on staff for medication administration, oral hygiene, toilet use, bathing, personal hygiene, dressing, and transfers. Resident #123 required the use of oxygen, tracheostomy care, and required an invasive mechanical ventilator. Resident #123 was assessed at risk for the development of pressure ulcers.<br><br>Review of Certified Nurse Aide (CNA) #145's personnel file revealed she was hired at the facility on [DATE]. Review of a disciplinary action document dated [DATE] revealed, upon doing wound rounds, it was noted several residents were soiled and not changed timely, not turned, and were not repositioned timely. The disciplinary action was marked as verbal counseling and was dated [DATE].<br><br>Interview with the Director of Nursing (DON) on [DATE] at 10:54 A.M. confirmed she was aware of an incident related to CNA #145 getting behind on her work and failing to change her assigned residents within the past two weeks. The DON stated she disciplined CNA #145 for leaving her residents soiled. The DON confirmed the facility failed to report an allegation of neglect when CNA #145 failed to provide care and services for Resident #59, Resident #122, and Resident #123 on [DATE]. The DON confirmed she did not complete a thorough investigation of the incident because she felt CNA #145 was a good aide and the DON did not receive complaints about CNA #145's care. The DON stated CNA #145 told her the reason she was behind on resident care on [DATE] was because she had a bad day.<br><br>Interview on [DATE] at 11:18 A.M. with CNA #145 confirmed she got very behind on her assignments on [DATE]. CNA #145 confirmed she failed to change the soiled sheets for Resident #59, Resident #122, and Resident #123 and confirmed she did not notify anyone that day of the care and services not being provided for those residents. CNA #145 confirmed did not ask the nurses or other CNAs for assistance with her residents because they were behind with care as well.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Arbors at Milford | 5900 Meadowcreek Drive<br>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.

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on [DATE] at 9:06 A.M. with Wound Nurse (WN) #150 confirmed three (#59, #122, and #123) residents were found lying on soiled sheets on [DATE] during her wound rounds. WN #150 stated on [DATE] at 5:00 P.M. she started her wound rounds down the 200 hallway. WN #150 confirmed Resident #59, Resident #122, and Resident #123 were all under the care of CNA #145 on [DATE]. WN #150 confirmed she found Resident #59 with very soiled and wet sheets, and Resident #123 was found with a dislodged tube feeding and had wet and dried tube feeding supplement all over his sheets. WN #150 stated Resident #123 had extremely compromised skin and should not lay in wet and soiled sheets. WN #150 also confirmed Resident #122 was found with his sheets soiled and saturated from his wounds. WN #150 explained how fragile Resident #122's skin was and the importance of keeping the resident's sheets clean and dry.<br><br>Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated [DATE], revealed an immediate investigation was warranted when suspicion of abuse, neglect, or exploitation, or report of abuse, neglect, or exploitation occur. The facility will identify the staff responsible for the investigation, identify and interview all involved persons, and provide complete and through documentation of the investigation. The facility will have written procedures for reporting alleged abuse, neglect, or exploitation. The procedures include reporting of alleged violations, immediately but no later than two hours after the allegation was made, if the events involve abuse or result in serious bodily injury, and no later than 24 hours if the events that cause the allegation do not involve abuse or result in bodily injury. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on medical record review, hospital documentation, personnel file review, review of self-reported incidents (SRIs), staff interview, and policy review, the facility failed to report the results of an investigation regarding resident neglect to the State Survey Agency in a timely manner and failed to thoroughly investigate allegations of neglect. This affected four (#59, #70, #122, and #123) of five residents reviewed for neglect. The facility census was 72.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, tracheostomy, end-stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus Type I, hypertension, chronic obstructive pulmonary disease, and chronic viral Hepatitis C.<br><br>Review of the Minimum Data Set (MDS) Discharge-return not anticipated assessment dated [DATE] revealed Resident #70 had no cognitive deficit and was always continent of bowel and occasionally incontinent of urine. The resident required set up assistance for eating, oral and personal hygiene, toileting and transfers, moderate assistance for bathing, supervision for dressing, and was independent with bed mobility.<br><br>Review of physician orders revealed Resident #70 had an order dated [DATE] to be administered the anticoagulant medication Eliquis 2.5 milligrams (mg) by mouth with instructions to give one tablet every morning and at bedtime.<br><br>Review of a fall risk evaluation dated [DATE] revealed Resident #70 was a low risk for falls.<br><br>Review of physician orders revealed an order dated [DATE] for Resident #70 to be administered aspart insulin with niacinamide 100 units per milliliter per sliding scale subcutaneously (SQ) before meals related to diabetes mellitus Type I. The sliding scale was as follows: for blood glucose levels between zero (0) and 59 milligrams per deciliter (mg/dL), implement hypoglycemia protocol; for blood glucose levels between 60 and 150 mg/dL, give 0 units; for blood glucose levels between 151 and 200 mg/dL, give two (2) units; for blood glucose levels between 201 and 250 mg/dL, give four (4) units; for blood glucose levels between 251 and 300 mg/dL, give six (6) units; for blood glucose levels between 301 and 350 mg/dL, give eight (8) units; for blood glucose levels between 351 and 400 mg/dL, give 10 units; for blood glucose levels between 401 and 450, give 12 units; and for blood glucose levels greater than 451 mg/dL, notify the physician.<br><br>Review of Resident #70's [DATE] medication administration record (MAR) revealed Resident #70 refused aspart insulin with niacinamide 100 units per milliliter as per sliding scale SQ before meals related to diabetes mellitus type I doses on [DATE] at 11:00 A.M. when the blood glucose levels was 170 mg/dL and at 4:00 P.M. when blood sugar level was 400 mg/dL, on [DATE] at 7:00 A.M. when the blood glucose level was 465 mg/dL and at 4:00 P.M. when blood glucose level was 450 mg/dL, on [DATE] at 11:00 A.M. when the blood glucose level was 220 mg/dL, and on [DATE] at 11:00 A.M. when the blood glucose level was 587 mg/dL.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a nursing progress note dated [DATE] at 7:46 P.M., written by Licensed Practical Nurse (LPN) #150, revealed Resident #70's glucose reading was 583 mg/dL. The nurse practitioner was notified, and an order was received to administer 16 units of insulin which Resident #70 refused. The resident had a history of non-compliance with the medication regimen. The resident was educated on the risks, up to and including death, of refusing physician orders. The resident was alert and oriented and repeated back understanding of the risks.<br><br>Review of a nursing progress note dated [DATE] at 2:42 A.M., written by previous Director of Nursing (DON) #395, revealed Resident #70 was found on the floor by a certified nurse aide. The resident was not answering questions but was able to move all extremities. The right side of the resident's face was slightly swollen. A neurologic examination was unable to be completed due to the resident not opening her eyes upon command.<br><br>Review of a nursing progress note dated [DATE] at 2:43 A.M., written by previous DON #395, revealed Resident #70 was assessed and the resident continued to move all extremities and her bilateral lower extremities which were over the side of the bed. The resident's respirations were easy yet unlabored and the resident continued to not follow commands.<br><br>Review of a nursing progress note dated [DATE] at 7:15 A.M., written by Licensed Practical Nurse (LPN) #155, revealed LPN #155 entered Resident #70's room to administer morning medications and obtain a fingerstick to check the resident's blood sugar and found the resident laying sideways across the bed with her legs dangling off the bed. The resident was noted with a bluish-colored skin tone and abdominal breathing. The resident's head was extremely edematous. The resident's cool air mist tubing was laying on her chest and not connected to the tracheostomy. A thick brown and blood-tinged sputum was noted in and around the tracheostomy. Resident #70 was unresponsive to verbal stimuli and sternal rub. LPN #155 called an emergency medical code at that time and two respiratory therapists immediately responded and initiated suctioning and providing breaths to the resident via a resuscitation (Ambu) bag. The resident's oxygen saturation was 94 percent (%) on the tracheostomy, the heart rate was 144 beats per minute, and the blood pressure could not be obtained. The respiratory therapists continued to provide respirations to Resident #70. At 7:24 A.M., emergency medical transport (EMT) personnel arrived on the scene and care was transitioned to them. At 7:27 A.M., EMT personnel remained on the scene providing first aid to the resident who continued to be unresponsive and with abdominal breathing. The resident's skin tone returned to a natural color. At 7:32 A.M., EMT personnel transported the resident from the facility to the hospital. A report was called to the receiving hospital emergency department (ED) and notifications were made to the physician and the resident's family. At 12:52 P.M., the resident was admitted to the hospital with a diagnosis of acute metabolic encephalopathy.<br><br>Review of hospital documents dated [DATE] at 1:09 P.M. revealed Resident #70 had a blood glucose level greater than 784 mg/dL and was admitted unresponsive on mechanical ventilation to the medical intensive care unit (MICU) with a concern for volume overload and flash pulmonary edema. The resident's temperature was 102.6 degrees Fahrenheit. The physician noted the resident was critically ill due to acute encephalopathy and comatose state and if untreated, there was a high risk of imminent or life-threatening deterioration of the resident's condition due to worsening hypoxic-ischemic brain injury, cerebral edema, seizures, brain compression and brain death. Further review of the hospital document revealed on [DATE] at 2:11 P.M., Resident #70 was also assigned a diagnosis of acute metabolic acidosis.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a nursing progress note dated [DATE] revealed the family reported Resident #70 expired in the hospital today.<br><br>Interview on [DATE] at 12:41 P.M. with Registered Nurse (RN) #390 verified there was no documentation that indicated neurological checks were performed on Resident #70 from the time she was found on the floor at [DATE] at 2:42 A.M. until she was transported to the hospital on [DATE] at 7:32 A.M. by EMT personnel or that the physician was notified of the resident's change in condition until transport to the hospital on [DATE] at 7:32 A.M.<br><br>Telephone interview on [DATE] at 1:12 P.M. with previous DON #395 verified neurological checks were not performed on Resident #70 after finding her on the floor on [DATE] at 2:42 A.M. through the time she was transported to the hospital on [DATE] at 7:32 A.M. Previous DON #395 also verified neither the physician, physician extender, nor family were notified of the resident's change in condition until after the resident was transported to the hospital. He was unable to provide rationale as to why neither neurological checks were obtained nor why the physician and family were not notified.<br><br>Telephone interview on [DATE] at 8:32 A.M. with Nurse Practitioner (NP) #195 verified it was the expectation for the facility to make immediate notification to the physician or physician extender for any resident who was experiencing or who had experienced a change in condition. NP #195 verified the facility did not make notification for Resident #70's change in condition until the resident was transported to the hospital on [DATE] at 7:32 A.M. NP #195 stated she should have been called immediately after the resident was found on the floor on [DATE] at 2:42 A.M., especially when it was noted the resident had swelling noted to the face and was on an anticoagulant medication.<br><br>Interview on [DATE] at 8:40 A.M. with the current DON revealed the findings of the facility's investigation were inconclusive as to how Resident #70 became to be on the floor in the early morning hours of [DATE]. The DON stated Resident #70 had a blanket on the floor and her oxygen tubing remained connected to her tracheostomy. The DON stated it was a strong possibility the resident placed herself on the floor and laid down. The DON did verify neurological checks were not completed on Resident #70 nor was the physician notified of the resident's change in condition until after transport to the hospital on [DATE] at 7:32 A.M.<br><br>Interview on [DATE] at 11:55 P.M. with NP #195 verified Resident #70 had a history of erratic blood glucose levels and stated the resident was afraid of being administered greater than 8 units of insulin for fear of it stacking up due to her diagnosis of type I diabetes mellitus. NP #195 verified the facility, and specifically previous DON #395, should have notified her immediately of the resident refusing the order for the 16 units of insulin on [DATE] at 7:46 P.M. and the resident should have been reassessed between [DATE] at 7:46 P. M. and [DATE] at 2:42 A.M. with an update provided. NP #195 also verified she would have definitely ordered the resident be sent to the hospital on [DATE] at 2:42 A.M. had she been notified by previous DON #395.<br><br>Review of facility self-reported incidents from [DATE] revealed no evidence the facility notified the State Survey Agency of a situation of neglect involving Resident #70's lack of assessment, treatment, and notification of change to the physician or nurse practitioner.<br><br>Interview on [DATE] at 6:46 P.M. with Regional Director of Clinical Operations (RDCO) #199 verified the facility did not submit their results of the investigation regarding the incident with Resident #70 in [DATE] to the State Survey Agency within five working days of the incident.<br><br>(continued on next page) |

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Medical record review for Resident#59 revealed he admitted to the facility on [DATE]. Diagnoses included orthostatic hypertension, cerebral vascular accident, depression, hypertension, hyperlipidemia, diabetes mellitus (DM), and respiratory failure.<br><br>Review of the MDS assessment for Resident #59, dated [DATE], revealed he had impaired cognition. Resident #59 was dependent on staff for oral hygiene, medication administration, toilet use, personal hygiene, bathing, dressing, transfers, and bed mobility. Resident #59 required a tube feed for nutrition and had an invasive mechanical ventilator.<br><br>3. Medical record review for Resident #122 revealed he was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure, osteomyelitis, dependence on respiratory ventilator, major depressive disorder, atrial fibrillation, acute kidney failure, dysphasia, and anxiety disorder.<br><br>Review of the MDS assessment, dated [DATE], revealed Resident #122 was cognitively intact. Further review of the MDS assessment confirmed Resident #122 was dependent on staff for medication administration, toilet use, lower body dressing, and putting on shoes. Resident #122 required assistance with meals and oral hygiene. He required maximum assistance with showering and required an invasive mechanical ventilator.<br><br>4. Medical record review for Resident #123 revealed he was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, major depressive disorder, essential primary hypertension, pulmonary embolism, cerebral infarction, and DM.<br><br>Review of the MDS assessment, dated [DATE], revealed Resident #123 had impaired cognition. Resident #123 was dependent on staff for medication administration, oral hygiene, toilet use, bathing, personal hygiene, dressing, and transfers. Resident #123 required the use of oxygen, tracheostomy care, and required an invasive mechanical ventilator. Resident #123 was assessed at risk for the development of pressure ulcers.<br><br>Review of Certified Nurse Aide (CNA) #145's personnel file revealed she was hired at the facility on [DATE]. Review of a disciplinary action document dated [DATE] revealed, upon doing wound rounds, it was noted several residents were soiled and not changed timely, not turned, and were not repositioned timely. The disciplinary action was marked as verbal counseling and was dated [DATE].<br><br>Interview with the Director of Nursing (DON) on [DATE] at 10:54 A.M. confirmed she was aware of an incident related to CNA #145 getting behind on her work and failing to change her assigned residents within the past two weeks. The DON stated she disciplined CNA #145 for leaving her residents soiled. The DON confirmed the facility failed to report an allegation of neglect when CNA #145 failed to provide care and services for Resident #59, Resident #122, and Resident #123 on [DATE]. The DON confirmed she did not complete a thorough investigation of the incident because she felt CNA #145 was a good aide and the DON did not receive complaints about CNA #145's care. The DON stated CNA #145 told her the reason she was behind on resident care on [DATE] was because she had a bad day.<br><br>Interview on [DATE] at 11:18 A.M. with CNA #145 confirmed she got very behind on her assignments on [DATE]. CNA #145 confirmed she failed to change the soiled sheets for Resident #59, Resident #122, and Resident #123 and confirmed she did not notify anyone that day of the care and services not being provided for those residents. CNA #145 confirmed did not ask the nurses or other CNAs for assistance with her residents because they were behind with care as well.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Milford | 5900 Meadowcreek Drive<br>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.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on [DATE] at 9:06 A.M. with Wound Nurse (WN) #150 confirmed three (#59, #122, and #123) residents were found lying on soiled sheets on [DATE] during her wound rounds. WN #150 stated on [DATE] at 5:00 P.M. she started her wound rounds down the 200 hallway. WN #150 confirmed Resident #59, Resident #122, and Resident #123 were all under the care of CNA #145 on [DATE]. WN #150 confirmed she found Resident #59 with very soiled and wet sheets, and Resident #123 was found with a dislodged tube feeding and had wet and dried tube feeding supplement all over his sheets. WN #150 stated Resident #123 had extremely compromised skin and should not lay in wet and soiled sheets. WN #150 also confirmed Resident #122 was found with his sheets soiled and saturated from his wounds. WN #150 explained how fragile Resident #122's skin was and the importance of keeping the resident's sheets clean and dry.<br><br>Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated [DATE], revealed an immediate investigation was warranted when suspicion of abuse, neglect, or exploitation, or report of abuse, neglect, or exploitation occur. The facility will identify the staff responsible for the investigation, identify and interview all involved persons, and provide complete and through documentation of the investigation. The facility will have written procedures for reporting alleged abuse, neglect, or exploitation. The procedures include reporting of alleged violations, immediately but no later than two hours after the allegation was made, if the events involve abuse or result in serious bodily injury, and no later than 24 hours if the events that cause the allegation do not involve abuse or result in bodily injury. The Administrator will follow up with government agencies, during business hours, to confirm initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on observation, resident and staff interview, medical record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and review of a government website, the facility failed to accurately code the status of a non-invasive mechanical ventilation on Minimum Data Set (MDS) assessments. This affected one (#60) of four residents reviewed for ventilators. The facility census was 72.<br><br>Findings include:<br><br>Medical record review for Resident #60 revealed she was admitted to the facility on [DATE]. Diagnoses included acute respiratory failure with hypoxia, pulmonary hypertension, congestive heart failure, asthma, essential primary hypertension, chronic kidney disease, anemia, dysphagia, and diabetes mellitus.<br><br>Review of the MDS assessment, dated 02/18/25, for Resident #60 revealed she was cognitively intact. Resident #60 was dependent on staff for medication administration, toilet use, and lower body dressing. Resident #60 required maximum assistance from staff with showers. Further review of the MDS assessment revealed Resident #60 required an invasive mechanical ventilator.<br><br>Review of the physician order summary for Resident #60 revealed an order, dated 02/14/25, for an Average Volume Pressure Support (AVAPS) Ventilator (VT) as needed with ordered settings every evening and night shift revealed to acute respiratory failure with hypoxia. Resident #60's also had an order dated 02/11/25 for staff to visually check ventilator dependent residents per the care plan and as needed every evening shift for resident status with instructions to check every two hours.<br><br>Interview and observation on 03/12/25 at 2:30 P.M. with Resident #60 revealed a Trilogy AVAP (non-invasive ventilator) on a rolling pole the resident stated she was connected to nightly via a continuous positive airway pressure (CPAP)/bilevel positive airway pressure (BiPAP) mask. At the time of the observation and interview, the resident was not connected to the Trilogy AVAP and not wearing the CPAP/BIPAP mask.<br><br>Interview with MDS Nurse #104 on 03/11/25 at 8:55 A.M. confirmed Resident #60 was coded on the MDS assessment dated [DATE] that the resident required an invasive mechanical ventilator. MDS Nurse #104 confirmed that was incorrect and Resident #60 should have been coded as a non- invasive mechanical ventilator. MDS Nurse #104 confirmed the AVAP ventilator was a non-invasive mechanical ventilator.<br><br>Review of a government website at, https://www.ncbi.nlm.nih.gov/books/NBK560600/#:~:text=Average%20volume%2Dassured%20pressure%20support%20(AVAPS)%20is%20a%20relatively, modality%20of%20non%2Dinvasive%20ventilation, under the title of, Average Volume-Assured Pressure Support, dated 08/08/23, revealed different modalities of non-invasive ventilation exist, with CPAP and BiPAP being the most commonly used modes. Average volume-assured pressure support (AVAPS) is a relatively newer modality of non-invasive ventilation that integrates the characteristics of both volume and pressure-controlled non-invasive ventilation.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Long-Term Care Facility RAI 3.0 User's Manual, version 1.19.1, dated October 2024, revealed, in section O0110F1, under Invasive Mechanical Ventilator (ventilator or respirator), staff are to code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support their own respiration in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or continuous positive airway pressure (CPAP).<br><br>Further review of the Long-Term Care Facility RAI 3.0 User's Manual, revealed, in section O0110G1, under Non-invasive Mechanical Ventilator, staff are to code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that breathe for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes their own BiPAP/CPAP mask/device. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASRR) was accurately completed. This affected one (#25) of two residents reviewed for PASRR. The facility census was 72.<br><br>Findings Include:<br><br>Medical record review for Resident #25 revealed she was admitted to the facility on [DATE] with hospice services. Diagnoses included morbid obesity, acute and chronic respiratory failure, obstructive sleep apnea, hypothyroidism, bipolar disorder, diabetes mellitus, peripheral vascular disease, anxiety disorder, major depressive disorder, and alcohol dependence.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #25, dated 02/15/25, revealed the resident was cognitively intact. Resident #25 was dependent on staff for medication administration, toilet use, bathing, lower body dressing, sit to lying position, chair to bed transfer, and tub transfer. Resident #25 required moderate assistance from staff with oral hygiene and set up assistance from staff with eating. Resident #25 required maximum assistance with upper body dressing and personal hygiene.<br><br>Review of the document titled, Preadmission Screening and Resident Result Notice, dated 02/19/22, confirmed Resident #25's diagnoses of anxiety disorder and bipolar disorder was not marked. The resident indicator of a serious mental health condition was only marked for mood disorder.<br><br>Interview on 03/11/25 at 2:39 P.M. with Director of Social Services (DSS) #191 confirmed Resident #25 admitted to the facility from another facility on 11/08/24. DSS #191 confirmed the PASRR dated, 02/18/22, was completed incorrectly and did not identify Resident #25's mental health diagnoses. DSS #191 confirmed the facility does not have a corrected PASRR on file.<br><br>Review of the facility policy titled, PASARR, Preadmission Screen and Resident Review, dated 10/30/23, confirmed a facility must coordinate with the pre-admission screening and resident review program under Medicaid. A nursing facility must not admit on or before January 1, 1989, new Residents with mental health diagnoses. All residents are required to have a Level 1 PASRR screen upon admission to the facility. If a Level II screen is required the facility will complete notification on the State's PASRR program notice for the Level II screen prior to or upon admission to the facility. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on observations, resident and staff interviews, medical record review, and policy review, the facility failed to develop care plans for dental care for residents with dental concerns. This affected one (#49) of three residents reviewed for dental care. The facility census was 72.<br><br>Findings Include:<br><br>Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included end stage renal disease with dependence on renal dialysis, combined congestive heart failure, and oropharyngeal dysphagia.<br><br>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #49 had no natural teeth and was not assessed as having loose fitting dentures.<br><br>Review of the care plan dated 02/24/24 revealed Resident #49 had no care plan for dental care.<br><br>During an interview on 03/10/25 at 1:01 P.M. Resident #49 stated his dentures did not fit due to recent gradual weight loss.<br><br>During an interview on 03/12/25 at 12:57 P.M. Social Worker #91 stated she had a care conference earlier this month to discuss concerns with weight loss. Resident #49 stated his gums hurt because his dentures were loose.<br><br>During an interview on 03/12/25 at 1:34 P.M. Registered Nurse (RN) #390 verified Resident #49 did not have an active care plan for dental care to address concerns with dental pain and loose-fitting dentures. |

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|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on medical record review, observation, staff interview, interview with the outside wound nurse practitioner (NP), review of the facility policy, and review of online guidelines per the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to thoroughly assess residents' skin and failed to identify pressure ulcers until they reached an advanced stage. This resulted in Actual Harm for Resident #123 who was admitted to the facility with a pressure ulcer to his sacrum and developed an additional pressure ulcer to his right scapula which was not identified until it was an unstageable ulcer with slough (nonviable tissue which could impede wound healing) and necrotic (dead) tissue. This affected one (Resident #123) of five residents reviewed for pressure ulcers. The facility identified five residents with in-house acquired pressure ulcers. The facility census was 72 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #123 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, major depressive disorder, essential primary hypertension, pulmonary embolism, cerebral infarction, diabetes mellitus, and sacral pressure ulcer.<br><br>Review of the admission skin assessment for Resident #123 dated 02/21/25 revealed the resident was admitted to the facility with a stage IV pressure ulcer to his sacrum.<br><br>Review of the shower sheet for Resident #123 completed by the Certified Nursing Assistant (CNA) dated 02/26/25 revealed the resident had no new skin issues.<br><br>Review of the progress note for Resident #123 dated 02/27/25 per Wound Nurse Practitioner (WNP) #250 revealed the resident had no wounds on his right shoulder.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #123 dated 02/28/25 revealed the resident had impaired cognition and was dependent on staff for activities of daily living (ADLs).<br><br>Review of the online bathing documentation for Resident #123 per the CNAs dated 03/01/25 to 03/06/25 revealed the resident had a bed bath on the following dates: 03/01/25, 03/02/25, 03/05/25.<br><br>Review of the pressure ulcer risk assessment for Resident #123 dated 03/06/25 revealed the resident was at high risk for the development of pressure ulcers.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the care plan for Resident #123 updated 03/06/25 revealed the resident had impaired skin integrity and was at risk for impaired skin integrity related to being confined to a bed all or most of the time, history of pressure ulcers, the need for assistance with ADLs, the need for repositioning, status post cerebral vascular accident (CVA), and ventilator use. Interventions included the following: apply protective barrier cream after in continent episodes, assist resident with turning and reposition as needed, complete skin inspection weekly and as needed, consult dietician as needed, elevate heels off the mattress, notify nurse of any new areas of skin impairment noted during bathing or daily care, notify physician of any new skin areas of skin impairment, pressure redistribution mattress, preventative treatments per orders, provide incontinence care as needed, provide a non-irritating surface to reduce friction or shearing forces.<br><br>Review of the nurse progress note for Resident #123 dated 03/06/25 per the facility wound nurse, Licensed Practical Nurse (LPN) #150, revealed during wound rounds the nurse and Wound Nurse Practitioner (WNP) #250 noted a Xeroform gauze dressing to the resident's right shoulder which was covering a pressure ulcer. Neither LPN #150 nor WNP #250 were able to determine how long the wound to the resident's right shoulder had been present.<br><br>Review of the progress note for Resident #123 dated 03/06/25 per WNP #250 revealed the resident had an unstageable pressure area to the right shoulder which measured 1.5 centimeters (cm) in length by 1.0 cm in width by 0.3 cm in depth. There was a medium amount of serosanguineous drainage from the wound with no granulation tissue within the wound bed. There was a large area of 67 percent (%) to 100 % of necrotic tissue and adherent slough tissue within the wound bed.<br><br>Review of the medical record for Resident #123 dated 02/21/25 to 03/06/25 revealed there were no skin checks completed by licensed nurses during this time frame.<br><br>Interview on 03/13/25 at 9:06 A.M with the facility wound nurse, LPN#150 confirmed the facility had not completed a pressure ulcer risk assessment for Resident #123 until 03/06/25 and determined the resident was at high risk for development of pressure ulcers. LPN #150 confirmed she completed wound rounds every Thursday with WNP #250, and facility nurses were expected to complete resident skin assessments on shower days twice weekly and notify her if they identified a new wound on a resident. LPN #150 confirmed the facility nurses had not completed skin assessments for Resident #123 from 02/21/25 to 03/06/25 and the CNA documentation dated 02/21/25 to 03/06/25 indicated the resident had no new skin issues. LPN #150 confirmed during wound rounds with WNP #250 on 03/06/25 they identified a pressure ulcer to Resident #123's right shoulder which was covered with an undated Xeroform gauze dressing. LPN #150 further confirmed when she completed wound rounds with WNP #250 on 02/27/25 there was no pressure ulcer or dressing present to Resident #123's right shoulder. LPN #150 confirmed the facility was unable to determine who had placed the dressing to Resident #123's right shoulder, and the facility had not identified the resident's pressure ulcer until 03/06/25 when the pressure ulcer to the resident's right shoulder presented as an unstageable ulcer due to slough and necrotic tissue within the wound bed.<br><br>Observation on 03/13/25 at 1:45 P.M. of wound care for Resident #123 per LPN #150 revealed the resident had a nickel-sized pressure ulcer to his right shoulder with yellow slough present in the wound bed.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 03/13/24 at 2:38 P.M. with WNP #250 confirmed the facility identified a new unstageable pressure ulcer to Resident#123's right shoulder during wound rounds completed on 03/06/25. WNP #250 confirmed the wound on Resident #123's right scapula was not present during wound rounds on 02/27/25 and was not identified by the facility until it had reached an advanced stage with slough and necrotic tissue present in the wound bed.<br><br>Review of the facility policy titled Pressure Injury Prevention Guidelines dated 10/30/20 revealed a resident at risk could develop a pressure ulcer within hours of the onset of pressure the at-risk resident needed to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Residents with pressure ulcers should receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers from forming.<br><br>Review of the NPUAP guidelines, dated 2014, pages 70-71 and located at, https://npiap.com/general/custom.asp?page=2014Guidelines, revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on observation, staff interview, and medical record review, the facility failed to ensure fall interventions were implemented as care planned. This affected one (#55) of five residents reviewed for falls. The facility census was 72.<br><br>Findings Include:<br><br>Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, epilepsy, type II diabetes, major depressive disorder, and stage III chronic kidney disease.<br><br>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care.<br><br>Review of care plan dated 04/29/24 revealed Resident # 55 was at risk for falls related to generalized weakness, poor balance, decreased strength and endurance, and need for assistance with activities of daily living (ADLs). Interventions included to encourage to rest in the afternoon, encourage to lay in the center of the bed, frequently monitor for infection, grab bars to the bed for repositioning, educate on safety interventions, encourage to use the call light, fall mats on floor to bilateral sides of bed, perimeter mattress, observe and report changes in activity levels, call light within reach, encourage the resident to be in common areas when awake, therapy screens as needed, and provide visual cues to assist with transfers.<br><br>Observation on 03/12/25 at 10:39 A.M. revealed Resident #55 had only one fall mat on floor located on the resident's right side of the bed. There were no other fall mats visible in the room, closet, or bathroom.<br><br>Observation on 03/12/25 at 3:09 P.M. revealed Resident #55 had only one fall mat on floor located on the resident's right side of bed. There were no other fall mats visible in the room, closet, or bathroom.<br><br>During an interview on 03/12/25 at 2:09 P.M. Registered Nurse (RN) #98 verified Resident #55 only had one mat on the floor in his room. RN #98 verified there were no other fall mats stored in the room and Resident #55 was care-planned for two fall mats.<br><br>This deficiency represents non-compliance identified under Complaint Number OH00162508. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Arbors at Milford | 5900 Meadowcreek Drive<br>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.

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on medical record review, staff interview, and physician interview, the facility failed to ensure a resident was assessed timely by the physician after admission. This affected one (#25) of three residents reviewed for physician visits. The facility census was 72.<br><br>Findings Include:<br><br>Medical record review for Resident #25 revealed she was admitted to the facility on [DATE] with hospice services. Diagnoses included morbid obesity, acute and chronic respiratory failure, obstructive sleep apnea, hypothyroidism, bipolar disorder, diabetes mellitus, peripheral vascular disease, anxiety disorder, major depressive disorder, and alcohol dependence. Resident #25 was discharged to the hospital on 01/31/25 and readmitted to the facility on [DATE].<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #25, dated 02/15/25, revealed Resident #25 was cognitively intact. Resident #25 was dependent on staff for medication administration, toilet use, bathing, lower body dressing, sit to lying position, chair to bed transfer, and tub transfer. Resident #25 required moderate assistance from staff with oral hygiene and set up assistance from staff with eating. Resident #25 required maximum assistance with upper body dressing and personal hygiene.<br><br>Review of the physician visit progress notes revealed Resident #25 was assessed by the physician on 11/11/24 and 12/16/24.<br><br>Interview on 03/13/25 at 3:28 P.M. with Medical Director (MD) #500 confirmed Resident #25 had not been assessed by a facility physician since 12/16/24. MD #500 confirmed Resident #25 readmitted to the facility on [DATE] from the hospital and had not been assessed since her readmission. MD #500 confirmed Resident #25 should have been assessed within thirty days of her admission. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771<br><br>Based on medical record review, observation, staff interview, pharmacist interview, and review of a facility policy, the facility failed to ensure insulin was properly dated and stored. This affected 10 (#2, #21, #23, #30, #49, #55, #62, #121, #124, and #321) of 26 residents the facility identified as receiving insulin. The facility census was 72.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, end-stage renal disease with dependence on hemodialysis, and congestive heart failure.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had severe cognitive impairment and was always incontinent of bowel and bladder. The resident received nutrition through an enteral feeding tube and was dependent for oral and personal hygiene, toileting, bathing, dressing, bed mobility, and transfers.<br><br>Review of physician orders revealed Resident #23 had an order dated [DATE] for Lispro insulin with meals per sliding scale and an order dated [DATE] for Basaglar insulin pen-injector 25 units subcutaneously at bedtime for diabetes mellitus type II.<br><br>Observation and interview on [DATE] at approximately 8:20 A.M. of the 900 nursing unit medication cart with Licensed Practical Nurse (LPN) #155 confirmed Resident #23's Basaglar insulin and Lispro insulin pen-injectors were not dated when removed from refrigerated storage and placed in the medication cart.<br><br>2. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, acute respiratory failure with hypoxia, tracheostomy, and hypertension.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #55 had moderate cognitive impairment and was frequently incontinent of bowel and bladder. The resident required set up assistance for eating, supervision for oral hygiene and bed mobility, and moderate assistance for toileting, bathing, dressing, personal hygiene, and transfers.<br><br>Review of physician orders revealed Resident #55 had an order dated [DATE] for Novolog insulin pen injector via sliding scale before meals.<br><br>Observation and interview on [DATE] at approximately 8:20 A.M. of the 900 nursing unit medication cart with LPN #155 confirmed Resident #55 had two Novolog insulin pen-injectors in the medication cart. One was dated [DATE] as being removed from refrigerated storage and placed in the medication cart and should have been discarded on [DATE]. The other Novolog insulin pen-injector was undated.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Review of the medical record revealed Resident #321 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, malignant neoplasm of the brain, and hypertension.<br><br>Review of the MDS assessment dated [DATE] revealed Resident #321 had no cognitive deficit and was always continent of bowel and bladder. The resident received nutrition through an enteral feeding tube and required set up assistance with oral hygiene, supervision with bed mobility and transfers, moderate assistance for toileting and dressing and maximal assistance with personal hygiene.<br><br>Review of physician orders revealed Resident #321 had an order dated [DATE] to be administered Glargine (Semglee) insulin pen-injector 46 units subcutaneously at bedtime for diabetes mellitus type II.<br><br>Observation and interview on [DATE] at approximately 8:20 A.M. of the 900 nursing unit medication cart with LPN #155 revealed Resident #321's Glargine (Semglee) insulin pen-injector was not dated when removed from refrigerated storage and placed in the medication cart.<br><br>4. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, end-stage renal disease with dependence on hemodialysis, and congestive heart failure.<br><br>Review of the annual MDS assessment dated [DATE] revealed Resident #30 had no cognitive deficit and was always incontinent of bowel and frequently incontinent of bladder. The resident required set up assistance with eating, supervision with oral hygiene and bed mobility, dependent for toileting and transfers, moderate assistance for bathing and personal hygiene, and maximal assistance for dressing.<br><br>Review of physician orders revealed Resident #30 had an order dated [DATE] for Glargine insulin pen-injector 11 units subcutaneously at bedtime for diabetes mellitus type II.<br><br>Observation and interview on [DATE] at approximately 8:20 A.M. of the 900 nursing unit medication cart with LPN #155 confirmed Resident #30's Glargine insulin pen-injector was not dated when removed from refrigerated storage and placed in the medication cart.<br><br>5. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, cerebrovascular accident with right (dominant) side hemiplegia and hemiparesis, and atrial fibrillation.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #2 had no cognitive deficit and was always incontinent of bowel and occasionally incontinent of bladder. The resident required set up assistance for eating, moderate assistance for oral hygiene and bed mobility, and was dependent for toileting, bathing, dressing, personal hygiene, and transfers.<br><br>Review of physician orders revealed Resident #2 had an order dated [DATE] for Glargine insulin pen-injector 24 units subcutaneously at bedtime for diabetes mellitus. This physician order was discontinued on [DATE].<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on [DATE] at approximately 8:20 A.M. of the 900 nursing unit medication cart with LPN #155 revealed Resident #2's Glargine insulin pen-injector was not dated when removed from refrigerated storage and placed in the medication cart. In addition, the resident's Glargine insulin pen-injector remained in the medication cart since the physician discontinued the order on [DATE].<br><br>6. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, end-stage renal disease with dependence on hemodialysis, and congestive heart failure.<br><br>Review of the significant change MDS assessment dated [DATE] revealed Resident #49 had no cognitive impairment and was frequently incontinent of bowel and always incontinent of bladder. The resident required moderate assistance for eating and oral hygiene, was dependent for toileting, bathing, dressing, and transfers, and maximal assistance for personal hygiene and bed mobility.<br><br>Review of physician orders revealed Resident #49 had an order dated [DATE] for Humalog insulin pen-injector subcutaneously one time a day for diabetes mellitus via sliding scale. Resident #49 was also ordered Glargine insulin insulin pen-injector 30 units subcutaneously at bedtime on [DATE] for diabetes mellitus type II.<br><br>Observation and interview on [DATE] at approximately 8:20 A.M. of the 900 nursing unit medication cart with LPN #155 confirmed Resident #49 had two Glargine insulin pen-injectors in the medication cart. One was dated [DATE] as being removed from refrigerated storage and placed in the medication cart and should have been discarded on [DATE]. The other Glargine insulin pen-injector and Humalog insulin pen-injectors were not dated.<br><br>Interview on [DATE] at 8:20 A.M. with LPN #155 verified the insulin pen-injectors for Resident #23, Resident #55, Resident #321, Resident #30, Resident #2, and Resident #49 were not dated when removed from refrigerated storage and placed in the medication cart. LPN #155 also confirmed Resident #55 and Resident #49 had insulin pen-injectors exceeded the 28 day use by date.<br><br>7. Review of the medical record revealed Resident #121 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, acute respiratory failure with hypoxia, and tracheostomy.<br><br>Review of the MDS assessment dated [DATE] revealed Resident #121 had severe cognitive impairment and was always incontinent of bowel and bladder. The resident required an enteral feeding tube for nutrition and was dependent for oral and personal hygiene, toileting, bathing, dressing, bed mobility, and transfers.<br><br>Review of physician orders revealed Resident #121 had an order dated [DATE] for Glargine insulin pen-injector 35 units subcutaneously at bedtime for diabetes mellitus type II and an order dated [DATE] for Lispro insulin pen-injector six (6) units subcutaneously four times a day for diabetes mellitus type II.<br><br>Observation on [DATE] at approximately 8:29 A.M. of the 200 (top) nursing unit medication cart with LPN #122 revealed Resident #121's Glargine insulin pen-injector and Lispro insulin pen-injector were not dated when removed from refrigerated storage and placed in the medication cart.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8. Review of the medical record revealed Resident #124 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, acute respiratory failure with hypoxia, tracheostomy, and cerebrovascular accident with right (dominant) side hemiplegia and hemiparesis.<br><br>Review of physician orders revealed Resident #124 had an order dated [DATE] for Lispro insulin pen-injector with meals via sliding scale for diabetes mellitus type II.<br><br>Observation on [DATE] at approximately 8:29 A.M. of the 200 (top) nursing unit medication cart with LPN #122 revealed Resident #124's Lispro insulin pen-injector was not dated when removed from refrigerated storage and placed in the medication cart.<br><br>Interview on [DATE] at 8:29 A.M. with LPN #122 verified the pen-injectors for Resident #121 and Resident #124 were not dated when removed from refrigerated storage and placed in the medication cart.<br><br>9. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II, chronic kidney disease, and heart failure.<br><br>Review of the annual MDS assessment dated [DATE] revealed Resident #21 had no cognitive deficit and was always incontinent of bowel and always incontinent of bladder. The resident required assistance with eating, partial to moderate assistance with oral hygiene and bed mobility, was dependent for toileting and transfers, require moderate assistance for bathing and personal hygiene, and required maximal assistance for dressing.<br><br>Review of physician orders revealed Resident #21 had an order dated [DATE] for Glargine insulin pen-injector 15 units subcutaneously at bedtime for diabetes mellitus type II.<br><br>Observation on [DATE] at approximately 8:35 A.M. of the 300 nursing unit medication cart with LPN #130 revealed Resident #21's Lispro insulin pen-injector was not dated when removed from refrigerated storage and placed in the medication cart.<br><br>10. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus type II with diabetic neuropathy, chronic obstructive pulmonary disease with (acute) exacerbation, and peripheral vascular disease.<br><br>Review of the annual MDS assessment dated [DATE] revealed Resident #62 had no cognitive deficit and was always incontinent of bowel and always incontinent of bladder. The resident required setup or clean-up assistance with eating, oral hygiene, and bed mobility, partial to moderate assistance for toileting and transfers, substantial to maximal assistance for bathing and personal hygiene, and maximal assistance for dressing.<br><br>Review of physician orders revealed Resident #62 had an order dated [DATE] for Glargine insulin pen-injector five (5) units subcutaneously at bedtime for diabetes mellitus type II.<br><br>Observation on [DATE] at approximately 8:35 A.M. of the 300 nursing unit medication cart with LPN #130 revealed Resident #62's Lispro insulin pen-injector was not dated when removed from refrigerated storage and placed in the medication cart.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on [DATE] at 8:35 A.M. with LPN #130 verified the insulin pen-injectors for Resident #21 and Resident #62 were not dated when removed from refrigerated storage and placed in the medication cart.<br><br>Interview on [DATE] at 1:57 P.M. with Consulting Pharmacist #385 verified insulin vials and/or pen-injectors must be dated when removed from refrigerated storage and that Glargine, Basaglar, Lantus, Lispro, Humalog, and Novolog insulins had an expiration date of 28 days after removal from refrigerated storage and placement in the medication cart.<br><br>Interview on [DATE] at 1:45 P.M. with the Director of Nursing (DON) verified insulin pen-injectors must be dated when removed from refrigerated storage and expired 28 days after removed from refrigerated storage.<br><br>Review of the policy titled, Storage of Medication, dated ,d+[DATE], revealed medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. Insulin products should be stored in the refrigerator until they are opened and note the date on the label for insulin vials and pens when first used. The opened insulin pens should be stored at room temperature. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>51520<br><br>Based on observation, staff interview, review of a planned menu, and policy review, revealed the faciity failed to follow the menu for residents ordered a regular diet. This affected 47 (#26, #21, #8, #28, #40, #58, #51, #49, #19, #31, #323, #44, #62, #56, #43, #30, #272, #37, #63, #24, #7, #48, #45, #271, #60, #57, #35, #3, #18, #32, #41, #10, #14, #324, #25, #33, #122, #15, #2, #50, #47, #64, #27, #38, #322, #39, and #54) of 47 residents ordered a regular diet. The facility census was 72.<br><br>Findings include:<br><br>Review of the menu for breakfast on 03/12/25 revealed assorted juice, choice of hot or cold cereal, scrambled eggs, bacon, hash browns, and milk/beverage.<br><br>Observation on 03/12/25 at 7:15 A.M revealed food to be served included hot or cold cereal, scrambled eggs, and hashbrowns, but no bacon was observed on the steam table.<br><br>Interview on 03/12/25 at 7:15 A.M with Dietary [NAME] #161 stated the kitchen did not have enough bacon for everyone, so they did not put any out and they were also out of sausage, so they did not prepare a substitute.<br><br>Review of the facility policy titled, Menus and Adequate Nutrition, revised on 01/01/22, revealed menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable and substitutions shall comprise of foods with comparable nutritive value. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>51520<br><br>Based on observation, staff interview, and policy review, the facility failed to store and prepare foods in a manner to prevent spoilage and contamination. This had the potential to affect all 62 residents who received food from the facility kitchen. The facility identified 10 (#1, #5, #23, #29, #59, #65, #121, #123, #124, and #321) who received no food from the kitchen. The facility census was 72.<br><br>Findings include:<br><br>1. Observation of the kitchen on 03/10/25 between 7:12 A.M. and 9:30 A.M., with Food Service Director (FSD) #157 revealed two packages of pie crusts undated and unlabeled in the dry food storage area. There were two packages of English muffins and six packages of rolls that were not dated. Observation of a garbage can located by the primary preparation station and a garbage can in the dishwashing room revealed neither garbage can had lids on them. Further observation of the kitchen revealed four ceiling air ventilator covers had black spots around the ventilators and a black substance built up on them.<br><br>Interview with FSD #157 verified the two packages of pie crusts were undated and unlabeled, verified the garbage cans by the preparation station and in the dishwashing room had no lids on them, the undated packages of English muffins and rolls, and the four ceiling air ventilators with black spots around them and build up on the ventilator at the time of the observations. FSD #157 further stated the maintenance department was responsible for cleaning the air ventilators.<br><br>Review of the facility policy titled, Food & Nutrition Services: QRT Food Storage, dated 09/01/21, revealed all food should be stored wrapped or in covered containers, labeled and dated, arranged in a manner to prevent cross contamination.<br><br>Review of the facility policy titled, Kitchen Sanitation, revised on 01/01/22, revealed kitchens, kitchen areas, and dining areas shall be kept clean and free from litter.<br><br>2. Observation on 03/11/25 at 7:20 A.M. revealed Dietary [NAME] (DC) #161 had gloves on while serving food on the tray line using serving scoops. DC #161 grabbed bread to put in the toaster using the same gloves he used while handling the serving scoops.<br><br>Interview on 03/11/25 at 9:00 AM with DC #161 stated he forgot to change his gloves and confirmed he touched food with his gloved hands without changing them.<br><br>Review of a facility policy titled, Hand Hygiene, revised 12/13/23, revealed all staff will perform hand hygiene procedure to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. |

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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062<br><br>Based on observation, staff interview, medical record review, and policy review, the facility failed to ensure proper personal protective equipment was worn while providing care and services for a resident on enhanced barrier precautions, failed to perform adequate hand hygiene between resident contact, and failed to ensure blood-contaminated materials were properly disposed of. This affected one (#47) of five residents reviewed for enhanced barrier precautions, one (#324) of two residents reviewed for laboratory services, one (#37) of one residents reviewed for blood glucose monitoring. The facility census was 72.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE]. Diagnoses included type II diabetes, end stage renal disease with dependence on renal dialysis, morbid obesity, and generalized anxiety disorder.<br><br>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively intact, had no behaviors, did not wander, and did not reject care.<br><br>Review of the medical record revealed Resident #47 had physician orders dated 01/24/25 to use enhanced barrier precautions while performing high-contact activities with the resident every day and night shift.<br><br>Review of care plan dated 06/26/24 revealed Resident #47 required enhanced barrier precautions related to dialysis and an enteral tube. Interventions included staff using gown and gloves when providing direct care and high contact activities and reviewing policies with visitors and family.<br><br>Review of the medical record revealed Resident #324 was admitted to the facility on [DATE]. Diagnoses included rheumatic disorders of the mitral and aortic valves, chronic diastolic heart failure, generalized anxiety disorder, and major depressive disorder.<br><br>Review of the most recent MDS assessment dated [DATE] revealed Resident #324 was cognitively intact, had no behaviors, did not wander, and did not reject care.<br><br>Observation on 03/11/25 at 9:03 A.M. revealed Laboratory Technician (LT) #400 entered Resident #47 and Resident #324's room wearing a face mask. LT #400 stated to Resident #47 she was taking a blood sample to check her hemoglobin A1C level. LT #400 donned gloves, set up supplies on the resident's bed, and placed the laboratory requisition on Resident #47's bedside table. LT #47 performed venipuncture, labeled the specimen tubes, placed used supplies in a sharp's container in her bag, filled out the paperwork, and doffed her gloves. LT #400 did not wash or sanitize her hands before she moved her bag from Resident #47 to Resident #324's bed, doffed clean gloves, drew blood from Resident #324's left antecubital space, bandaged the puncture site, placed sharps and medical waste in the container in her bag, filled out papers, and placed specimen tubes in a side pocket. LT #400 secured the paper in her bag, doffed her gloves, and did not wash or sanitize her hands before leaving the room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Milford | 5900 Meadowcreek Drive<br>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.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/11/25 at 9:19 A.M. LT #400 verified she did not wear a gown while providing venipuncture to Resident #47. LT #400 stated she did not work for the facility or provide care for the residents. LT #400 verified she did not have sanitizer in her bag, and she did not use resident bathrooms to wash her hands before leaving the room.<br><br>2. Review of the medical record revealed Resident #37 was admitted to the facility on [DATE]. Diagnoses included chronic systolic heart failure, type II diabetes, unspecified schizophrenia, and unspecified anxiety disorder.<br><br>Review of the most recent MDS assessment dated [DATE] revealed Resident #37 was cognitively intact, had no behaviors, did not wander, and did not reject care.<br><br>Observation on 03/13/25 at 8:48 A.M. revealed Licensed Practical Nurse (LPN) #130 entered Resident #37's room wearing gloves and carrying supplies to assess the resident's blood glucose level. LPN #130 performed the test and placed the soiled glucometer strip and gloves in the resident's trash can, washed her hands in sink, and left room with glucometer and used lancet.<br><br>During an interview on 03/13/25 at 8:57 A.M. with LPN #130 stated she threw used lancets in the trash can on nurse's cart and verified she placed the soiled glucometer strip in Resident #37's trash can after blood was obtained from the resident to check her blood glucose level. LPN #130 stated she was never trained to put used glucometer strips in the sharp's container but stated it made sense because the lancet had blood on it. LPN #130 stated she knew lancets needed to be disposed of in the sharp's container.<br><br>Review of policy titled, Contaminated Materials, revised 12/13/23 revealed materials contaminated with blood or body fluids were discarded appropriately in biohazard containers. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365675 | A. Building<br>B. Wing | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Milford | 5900 Meadowcreek Drive<br>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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771<br><br>Based on medical record review, observation, and staff interview, the facility failed to maintain a safe and clean environment. This affected three (#12, #14, and #46) of 12 residents reviewed for environment. The facility census was 72.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, congestive heart failure, hypertension, diabetes mellitus type II, and dementia.<br><br>Observation on 03/10/24 at 10:15 A.M. revealed Resident #46's room had an area of the wall located below heating ventilation and air conditioning (HVAC) unit that was unpainted drywall was stained with a black substance.<br><br>2. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses of cerebrovascular accident with right (dominant) side hemiplegia and hemiparesis, chronic obstructive pulmonary disease, diabetes mellitus type II, morbid obesity, alcoholic cirrhosis, and congestive heart failure.<br><br>Observation on 03/10/25 at 9:38 A.M. revealed Resident #14's room had a hole in the wall to the right of the television that measured approximately seven inches long and three inches wide at the widest point.<br><br>Observation and interview on 03/12/25 from 9:30 A.M. to 9:37 A.M. with Maintenance Director (MD) #103 verified the area of Resident #46's wall below the HVAC unit which was unpainted drywall with a black substance on it and verified the hole in the wall to the right of Resident #14's television.<br><br>3. Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease with exacerbation, and contracture of the left hand.<br><br>Observation of Resident #12's room on 03/10/25 at 11:31 A.M. revealed a hole in the wall behind the door that had a towel in the hole.<br><br>Interview on 03/10/25 at 11:32 A.M. with the Assistant Director of Nursing (ADON) verified there was a towel stuffed in the hole in the wall behind Resident #12's door.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00162132.<br><br>51520 |