STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365689	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Fairlawn The	575 S Cleveland Massillon Road Fairlawn, OH 44333

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on observation, record review, and interviews the facility failed to ensure all treatments were completed per physician orders for Resident #39. This affected one resident (Resident #39) of four residents reviewed for treatment administration. The facility census was 69. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including malignant neoplasm of the skin, hypothyroidism, dementia, Alzheimer's disease, and hypertension. Review of Resident #39's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition. Resident #39 required set up help only for eating, partial to moderate assistance for oral hygiene, substantial to maximal assistance for toileting, dressing, personal hygiene, and bed mobility. Resident #39 was dependent for showers. Review of Resident #39's physician orders dated August 2024, September 2024, and October 2024 revealed orders to cleanse biopsy sites with soap and water, Mupirocin two percent (2%) cream to be applied to biopsy sites and covered with a bandage daily for 10 to 14 days post procedure. Review of Resident #39's Treatment Administration Record (TAR) dated August 2024 and September 2024 revealed the treatment to her biopsy sites were not completed on 08/28/24, 08/29/24, 09/07/24, 09/08/24, 09/23/24, 09/26/24, 09/29/24, and 09/30/24. Interviews conducted throughout the survey on 10/01/24 at 2:18 P.M. with Registered Nurse (RN) #605, on 10/02/24 at 9:40 A.M. with Licensed Practical Nurse (LPN) #655 and on 10/03/24 at 3:52 P.M. to 3:59 P.M. with RN #612 and RN #648 verified there were times when Resident #39 did not have her treatment to the biopsy sites completed as ordered by the physician. Interview conducted on 10/01/24 at 3:02 P.M. with Resident #13, on 10/02/24 at 11:00 A.M. and 2:15 P.M. with Resident #65 and Resident #64, and on 10/03/24 between 3:48 P.M. to 4:02 P.M. with Resident #53, #69 and #70 revealed at times their treatments were not completed as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00157498.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on medical record review, review of the ambulance run report, review of hospital documents, review of the facility Self-Reported Incident (SRI) investigation, and interviews, the facility failed to ensure Resident #73 was provided a transfer to bed in a safe manner to prevent an incident/accident with major injury. Actual harm occurred on 08/25/24 when Resident #73, who was severely cognitively impaired and dependent on two staff with maximal assistance needed for transfers, sustained a 10-centimeter laceration that went to the bone with profuse bleeding to her right calf during a staff assisted transfer. As a result of the incident/injury, Resident #73 was emergently transferred to the local hospital on 08/25/24 for treatment which included 21 sutures to the wound. The resident also exhibited increased pain because of the injury as evidenced by her yelling out following the incident. This affected one resident (Resident #73) of four residents reviewed for accident hazards. The facility census was 69. Findings include: Review of Resident #73's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease with late onset, dementia, cerebral vascular accident, hemiplegia, hemiparesis affecting the right dominant side, chronic kidney disease (Stage 3B), and hypertension. Resident #73 was discharged on [DATE] to the local hospital and then discharged home with her family from the hospital on 08/27/24. Review of Resident #73's care plan which was initiated on 08/12/24 revealed a care plan related to the resident having an activity of daily living (ADL) self-care performance deficit with interventions including one person assist for bed mobility, toileting/incontinence care, supervision with meals with staff to offer assistance with meal setup as needed. Additionally, there was an intervention initiated on 08/28/24 for a transfer status requiring two staff members and the use of the Hoyer(mechanical) lift. Review of Resident #73's physician orders dated August 2024 revealed there were no orders indicating how the resident should be transferred. Review of Resident #73's progress notes revealed there was an entry made on 08/25/24 at 11:10 P.M. authored by Licensed Practical Nurse (LPN) #655 indicating she was called into the resident's room for bleeding. LPN #655 pulled the resident's pant leg back and noticed excessive bleeding. The nurse applied pressure, cleaned and wrapped the resident's leg and called 911 for the resident to go to the emergency room (ER). There was no documentation explaining how the injury happened or whether the family or the physician were notified of the resident's transfer to ER. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the ambulance run report dated 08/25/24 revealed a 911 call was received at 9:39 P.M., the ambulance was dispatched to the facility at 9:41 P.M., arrived on scene at 9:48 P.M., made first contact with Resident #73 at 9:51 P.M., and departed the facility with Resident #73 at 10:07 P.M. The report revealed Emergency Medical Services (EMS) were dispatched to the facility for a female resident with a leg injury. Upon arrival EMS found the resident in bed, with her lower right leg wrapped. A nurse in the room advised EMS the resident had a six-inch laceration down to the bone and it was unknown how it happened. The nurse stated the leg was spurting blood. EMS were unable to examine the wound because the resident was not allowing them to touch her leg. Review of the local hospital paperwork revealed Resident #73 was brought to the emergency roiagnom on [DATE] at 10:24 P.M. and discharged home with her family on 08/27/24. The findings at the hospital included the resident had a 10-centimeter laceration to her right calf exposing bone and requiring 21 sutures. The laceration was thought to be caused by an accident at the facility. Resident #73 was not able to provide any history due to severe dementia and the resident's daughter said they did not know how the injury occurred but verified it did occur at the facility. Diagnostic work up included x-rays/scans to the head, pelvis and lower extremities. Besides the soft tissue swelling at the site of the laceration on the right calf, there were no additional findings of fractures or other acute injuries. There were no indications of infection related to the laceration. Review of Resident #73's discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. The assessment revealed Resident #73 required set-up or clean up assistance for eating and was dependent on staff for all other ADL care including oral hygiene, toileting, showers, dressing, personal hygiene, and bed mobility. The assessment indicated Resident #73 was dependent on maximal assistance from two staff members for all transfers. Review of a facility Self-Reported Incident (SRI) dated 08/26/24 revealed the facility reported an injury of unknown origin involving Resident #73. Information contained in the SRI revealed Resident #73 sustained a laceration to the right lower extremity on 08/25/24 while being transferred to bed by State tested Nursing Assistant (STNA) #640 and STNA #658. The SRI noted the facility did not determine the incident was a result of resident abuse. Review of a witness statement dated 08/25/24 and authored by Licensed Practical Nurse (LPN) #655 revealed she had been sitting at the nurse's station when both aides came to me stating (resident's name) was bleeding from leg. I went to room, pulled down resident pant legs and notice blood and deep cut. I asked what happen, both aides stated they did not know. Resident was screaming in pain. I applied pressure to wound cleaned and called 911 to be sent out. Review of a witness statement dated 08/25/24 and authored by STNA #626 revealed Resident #73 had been sitting at the nurse's station until it was time for her to go to bed. Around 9:30 P.M. two aides (no names specified) went into her room to put her to bed, and one came back out yelling she was bleeding and went into the bathroom to clean up. STNA #626 went to help the nurse with Resident #73 and Resident #73 was laying in bed yelling while the nurse pulled up the resident's pant leg back and that was when STNA #626 saw the wound and blood all on the floor. There was no indication in the witness statement that Resident #73 had been bleeding while in the hallway prior to being transferred to bed by STNA #640 and STNA #658. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement dated 08/25/24 and authored by STNA #640 revealed she took Resident #73 to the nurse's station after dinner. At 9:30 P.M. she transferred Resident #73 to her bed with the assistance of STNA #658 and noticed blood. Before dinner, STNA #640 and STNA #658 had stood Resident #73 up to check her brief and it was dry, so they took her to the dining room for dinner. There was no indication in the witness statement that Resident #73 had been bleeding while at dinner prior to being transferred to bed by STNA #640 and STNA #658. Interview on 10/01/24 at 1:18 P.M. with Family Member #800 revealed they initially were told by the facility staff that the staff did not know how the injury occurred, however, after asking multiple questions they stated STNA #640 and STNA #658 explained to them it happened during the transfer from the resident's transport chair to the resident's bed. Family Member #800 stated STNA #640 and STNA #658 told them when they were transferring the resident with only two staff members it was difficult to do the transfer, and they should have been using a Hoyer lift on her. Family Member #800 felt the injury could have been avoided if they were transferring the resident correctly. Interview on 10/02/24 at 9:40 A.M. with LPN #655 revealed on 08/25/24 Resident #73 was taken down to her room so she could be put to bed. One STNA came out of the resident's room yelling the resident was bleeding and she had blood all over her pants and hands. The nurse went to the resident's room immediately and found the resident was laying in bed, she had on grey sweatpants and the resident's right leg was wet with blood, so she pulled the resident's pant leg back and found a bleeding laceration with blood coming out very fast, so she immediately applied pressure. LPN #655 stated there was a second nurse in the room who went to get supplies to dress the laceration. LPN #655 then stated she called the Director of Nursing (DON) on facetime to show her the resident's leg. The DON directed her to dress it and to call 911 to have the resident go to the emergency room (ER). LPN #655 stated she knew the resident would need stitches. She stated two STNAs transferred the resident to bed. When asked when the last time she saw the resident she stated just prior to the STNAs putting her to bed at the nurse's station. LPN #655 stated there was no blood at the nurse's station, however there was blood on the resident's floor next to and under her bed. LPN #655 did state she spoke to the resident's daughter and son. She stated Resident #73's son did call back in and began to ask questions on how the injury happened. LPN #655 stated she told the son it happened when the two STNAs transferred Resident #73 to bed. LPN #655 stated they told the resident's son she did not know exactly what happened though due to not being in the room for the transfer. LPN #655 also stated she had not received any education recently on gait belt use, resident transfer status, or with reporting changes. She stated she did not attend an in-person training, nor did she receive any messages from the facility regarding any education following the incident. Interview on 10/02/24 at 1:00 P.M. with the DON verified Resident #73 required the use of a mechanical (Hoyer) lift with two staff members for transfers since her admission on 08/12/24. The DON then stated there had been a communication breakdown between therapy and the nursing department on Resident #73's transfer status. She also confirmed at this time there were no behaviors documented for Resident #73, although she was anxious and would become resistive to care at times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/02/24 at 1:14 P.M. with Physical Therapist (PT) #675 revealed he completed an initial therapy assessment on Resident #73, and he was able to transfer the resident with a stand pivot technique. He stated he felt if the staff on the floor were to transfer the resident with two staff members, they would be able to complete the transfer with no issues but had heard some of the STNAs were having difficulty with this type of transfer. PT #675 denied being asked to re-evaluate the resident's transfer status. PT #675 stated after the incident on 08/25/24 he completed re-assessments on resident's related to their transfer status to ensure all were correct and adjustments were made if needed. Interview on 10/02/24 at 1:30 P.M. with Certified Occupational Therapy Assistant (COTA) #676 revealed Resident #73 did receive Occupational Therapy (OT) where they did stretch exercises with the resident. COTA #676 stated she remembered hearing Resident #73 was difficult to transfer. Interview on 10/02/24 at 2:05 P.M. with the DON revealed the facility had not completed any type of inspection on the resident's wheelchair (which had been brought with her at the time of admission). She stated the family brought the resident to the facility in a transport chair and they did not issue the resident a standard wheelchair. The family came in at around 7:00 A.M. on 08/26/24 and took all the residents' belongings including the transport chair. Interview on 10/02/24 at 3:07 P.M. with STNA #640 revealed she was assigned to Resident #73 on 08/25/24. STNA #640 stated she waited to put the resident to bed until last and had her at the nurse's station due to the resident being a fall risk. STNA #640 stated once STNA #658 came back in from supervising a smoke break with other residents between 9:30 P.M. and 9:45 P.M. STNA #658 stated Resident #73 was a two-assist transfer so both STNA's transferred the resident to her bed. As STNA #658 was lifting Resident #73's legs into the bed Resident #73 began to scream my leg, my Leg!. STNA #640 stated STNA #658 had blood all over her hands and on her pants. STNA #640 stated as STNA #658 ran out of the room she yelled to the nurse the resident was bleeding. STNA #640 stated there was a puddle of blood on the floor and the resident's sweatpants were soaked in blood on the right pant leg. STNA #640 stated when the resident first arrived at the facility no one informed her how to transfer the resident and Resident #73 was a very difficult two- person transfer. STNA #640 stated she felt the resident should have been a Hoyer lift. STNA #640 stated the resident was not able to help with the transfer as she could not or would not bear weight on her right leg as it was affected from when the resident had a previous stroke prior to coming to the facility. STNA #640 stated the resident was not anxious or combative with care as she was joking with STNA #658 prior to the transfer and hugged her. STNA #640 stated she was unsure what the resident cut her leg on but knew it happened during the transfer. There was no information provided during the interview to indicate the staff used a mechanical (Hoyer) lift at the time of this transfer. Interviews conducted on 10/02/24 at 3:55 P.M. with STNA #614 and at 3:59 P.M. with Registered Nurse (RN) #612 revealed they had not received any education recently on gait belt use, resident transfer status, or with reporting changes. They stated they did not attend any type of in-person training, nor did they receive any messages from the facility regarding education following the incident with Resident #73 on 08/25/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/03/24 at 4:21 P.M. with STNA #658 verified she helped put Resident #73 to bed the night of 08/25/24. STNA #658 stated she was unsure of the time, but stated it was after the 9:00 P.M. smoke break. She stated Resident #73 did not bear weight and they would have to physically pick the resident up when transferring her to bed. The STNA also stated she did not believe the resident was using an appropriate wheelchair as the family brought her to the facility in a transport chair and they were not issued a standard wheelchair for the resident. STNA #658 stated she and STNA #640 manually transferred Resident #73 to bed and were picking up the resident's legs when they felt something wet. When she looked down there was blood all over her hands and on her pant leg. STNA #658 stated she ran out of the room and yelled for the nurse and ran to the bathroom to wash her hands and pant leg. STNA #658 stated she went back down to the room and found two nurses and STNA #640 applying pressure to the resident's leg and trying to dress it. STNA #658 stated there was blood dripping on the floor in a puddle and there was blood all over the resident's bed. STNA #658 stated an ambulance showed up and took the resident to the hospital, and the resident did not return to the facility. STNA #658 stated she was unsure what the resident cut her leg on but knew it happened during the transfer. There was no information provided during the interview to indicate the staff used a mechanical (Hoyer) lift at the time of this transfer. Interview on 10/08/24 at 5:23 P.M. with the DON confirmed Resident #73 had a transfer status in her care plan initiated on the day of admission 08/12/24 indicating the resident was to be transferred with the use of two staff members. The DON stated this was triggered from answers given during the completion of the admission assessment. The DON stated she was unsure who completed the admission assessment. Review of the facility policy titled Accidents and Supervision, date revised 12/27/23, revealed each resident would be assessed for accident risk and would receive care and services in accordance with their individualized care plan. Each resident would receive adequate supervision and assistive devices to prevent accidents including identifying, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks and monitoring effectiveness and modifying interventions when necessary. An accident was defined as any unexpected or unintentional incident which resulted in injury or illness to the resident. Hazards referred to elements in the resident environment that had the potential to cause injury or illness. Risk referred to any external factor, facility characteristics (e.g.: staffing or physical environment) or characteristic of an individual resident that increases the likelihood of an accident. Supervision/Adequate Supervision referred to intervention and means of mitigating risk of an accident. The facility should make a reasonable effort to identify the hazards and risks for each resident. The facility should use specific interventions to try to reduce a resident's risk from hazards including providing training to staff, communicating the interventions to relevant staff and implementing specific interventions as part of the care plan. This deficiency represents non-compliance investigated under Complaint Number OH00157777.