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	01/09/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review and interview, the facility failed to ensure Resident #74 and resident representatives were properly notified in writing of an emergency discharge for Resident #74. This affected one resident (Resident #74) of three residents reviewed for discharges. The facility census was 72. Findings include: Review of the closed record for Resident #74 revealed an admitted [DATE] with diagnoses including schizoaffective and mood affective disorder, unspecified intellectual disabilities, sexual dysfunction not due to a substance or known physiological condition, anxiety, insomnia, manic episodes, and assistance with personal care. Resident #74 was transferred to the hospital for an acute, inpatient psychiatric stay on 12/09/24 and did not return to the facility. Resident #74 had a legal guardian of person. Review of Resident #74's Minimum Data Set (MDS) 3.0 discharge return not anticipated assessment dated [DATE] revealed Resident #74 was modified independent for cognitive daily decision making, no delirium was noted. Resident #74 was positive for inattention, but no disorganized thinking or altered level of consciousness was noted. No hallucination noted but delusions were present. No physical behaviors towards others were displayed but verbal behaviors towards others were displayed daily. Rejection of care occurred daily and wandering occurred daily. Resident #74 was independent for eating, oral hygiene, dressing and toilet hygiene but needed supervision for showers. Resident #74 was independent with mobility such as rolling left and right in bed, sitting on the side of the bed and bed transfers but needed supervision for shower transfers. Resident #74 was independent to walk ten feet. Review of Resident #74's care plan, dated 11/18/24 revealed Resident #74 had behaviors related to a diagnosis of schizoaffective disorder, generalized anxiety disorder, unspecified mood disorder and manic episodes, dementia as evidenced by aggressively hugging and grabbing staff, pacing throughout facility without footwear, attempts to chase after staff, nonsensical statements verbally and written notes on a note pad, taking items from residents rooms, and refused medication. Intervention included offer and provide activities of interest to keep resident engaged, administer medication as ordered, engage resident in simple, structured activities that avoid overly demanding tasks, labs as ordered, notify physician of any significant change in resident's baseline cognitive status. Physical therapy, occupational therapy and speech therapy as needed. Refer to psychological/psychiatrist as needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365689	A. Building B. Wing	01/09/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Situation Background, Assessment and Recommendation (SBAR) note dated 12/09/24 at 11:00 A.M. written by Nurse Practitioner (NP) #511 revealed Resident #74 had a change in condition with psychotic behaviors that started on 12/06/24 and have gotten worse. Worse behaviors included following staff, unable to re-direct regarding personal space. Resident refused to allow vitals to be taken. Treatment included as needed psychological medication and inpatient psych stay. Resident #74 was admitted to the nursing home for long term needs. Mental status changes included new or worsening behavior symptoms, no functional status change, no gastrointestinal change, no urine change. Problems included increased psychotic behaviors due to inability to self-regulate, medication was ineffective, inappropriate level of care in facility. It was suggested Resident #74 transfer to the hospital. Guardian was notified of erratic behaviors, ineffective medication, inability to redirect, threatening others, intrusiveness, inappropriate touching and obsession with religion. The facility notified the guardian/mother of intention to send to the emergency department and not accept Resident #74 back since this was not an appropriate environment for Resident #74 to live in. Review of the facility document Application for Emergency Admission (commonly known as pink slip which commits the resident involuntarily to the hospital), dated 12/09/24, revealed Resident #74 represented a substantial risk of physical harm to others manifested by evidence of recent homicidal or other violent behavior and would benefit from treatment in a hospital for his mental illness and was in need of such treatment as manifested by evidence of behavior that created a grave and imminent risk to substantial right of others or himself. The documented revealed Resident #74 was exhibiting threatening, impulsive behaviors since admission. Behaviors escalated into obsession about religious persecution and ideation and threats of physical harm. Resident #74 was intrusive, threatening towards other nursing home residents and had threatened to kill staff members and was physically capable of acting out these threats. Resident #74 experienced auditory hallucinations but would not reveal what the voices said. Resident #74 had attempted to leave the facility unattended by going to the exit doors and pushing on the doors. This created a substantial risk to his safety as well as others because the facility was located on a highway exit. Resident #74 required admission to an inpatient intensive psychiatric stay to improve the quality of life and to provide safety to the community. The Application for Emergency Admission was signed by the facility Medical Doctor # 513. Review of the facility document titled Immediate Involuntary Discharge, dated 12/09/24, revealed the document indicated it was hand delivered. The document indicated Resident #74 was notified he was immediately discharged because an emergency arose in which the safety of individuals in the home was endangered. Resident #74 had the right to request an impartial hearing at the facility concerning the proposed discharge. Resident #74 could challenge the discharge and request a hearing by sending in a request by resident or sponsor for a hearing within 30 days of receipt of the notice to the Ohio Department of Health Legal Services Office. If the resident or sponsor received the request within 10 days of the date of the notice, the facility would not discharge the resident prior to the hearing. Agency contact and Ombudsman contact information was provided. Interview on 01/08/25 at 8:18 A.M. with the hospital Supervisor of Behavior Health Social Work (SBHSW) #510 revealed Resident #74 was sent to the in-patient psychiatric unit for help and the current nursing facility he resided in would not take him back so he was still at the hospital while they tried to find him placement. The facility dropped off his belongings with a letter of immediate discharge in the bag which was not brought to the hospital or resident's attention at the time his belongings were dropped off at the hospital. SBHSW #510 stated Resident #74's mother and guardian stated to SBHSW #510 they did not receive an immediate discharge notice from the facility. (continued on next page)

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	01/09/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/08/25 at 4:00 P.M. with Ombudsman #509 revealed the facility provided an immediate discharge notice to the hospital by placing it in Resident #74's bag of belongings the facility dropped off. Ombudsman #509 stated Resident #74's mother wanted him to return to the same nursing facility upon discharge from the hospital because he needed assistance with medication. Ombudsman #509 stated Resident #74's mother and legal guardian had not received in writing notification of emergency discharge. Interview on 01/08/25 at 4:32 P.M. with Resident #74's Legal Guardian #507 revealed as of 01/07/25 she was transitioned as legal guardian, but Resident #74's mother still had input in Resident #74's care. Legal Guardian #507 stated the nursing facility stated they could not handle his care so they implemented an emergency discharge. Legal Guardian #507 stated the facility did not communicate when Resident #74 was admitted to the hospital therefore Resident #74's mother was not able to communicate with her son in the hospital. Interview on 01/09/25 at 9:47 A.M. with facility Nurse Practitioner (NP) #511 revealed the facility recommended a pink slip because Resident #74 was running up the hallway, threatening staff and felt residents were not safe. NP #511 verified Resident #74 was immediately involuntarily discharged to the hospital on 12/09/24. Interview on 01/09/25 at 10:37 A.M. with the facility Social Services (SS) #503 verified Resident #74 was emergently discharged from the facility on 12/09/24 because of behaviors the facility could not manage placing other residents at risk. SS #503 also verified Resident #74's guardian or mother did not receive a 30-day discharge notice or right to appeal but was sent an emergent discharge notice and she did not call the hospital for discharge planning or goals to ensure the notice in writing was received by the resident or legal guardian. Interview on 01/09/25 at 11:00 A.M. with the Administrator who revealed the facility transportation person hand delivered the immediate discharge document to the resident in the emergency room , and the immediate discharge notice was sent to the Guardian and mother by mail but not certified mail so there was no evidence either had received the written notice. Interview on 01/09/25 at 1:14 P.M. with Resident #74's mother revealed currently the hospital could not find a nursing facility for her son to live and the facility would not take her son back. The facility did not tell her Resident #74 was discharged so she thought Resident #74 would be returning to the facility. She stated she never received an immediate discharge notice. Resident #74's mother also stated at no time did she agree with the facility not to take her son back. Interview on 01/09/25 at 1:47 P.M. with the Director of Nursing (DON) revealed the immediate discharge letter was not sent by certified mail to Resident #74's mother or guardian therefore she had no proof the letter was sent. The DON also stated the facility did not plan to take Resident #74 back so he was discharged to the hospital with no anticipated return. (continued on next page)

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	01/09/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/25 at 2:13 P.M. with hospital SBHSW #510 revealed on 12/10/24 Resident #74's mother stated she wanted her son to return to the facility and did not know her son was discharged from the facility. SBHSW #510 further added the immediate discharge letter was not hand delivered to the resident. Resident #74 was in the emergency department on 12/09/24 at 5:46 P.M. and was transferred to the psychiatric unit on 12/10/24 at 1:10 A.M., and all of resident #74 's belongings were brought with him from the emergency department. On 12/10/24 at 2:55 P.M. hospital security notified her Resident #74's belongings were dropped off on the second floor of the hospital. When SBHSW #510 inspected the bag on the unit the immediate discharge letter was in the bag of resident's belongings which the resident did not have access to. Review of facility policy titled Readmission to Facility dated 07/28/20 revealed if the facility does not permit the resident to return to the facility, the facility must notify the resident and resident representative in writing of the discharge including appeal rights. This deficiency represents non-compliance investigated under Complaint Number OH00160679.

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	01/09/2025

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, interview and review of facility policy, the facility failed to collaborate with the hospital to ascertain an accurate status of Resident #74's condition before refusing to allow Resident #74 to return to the facility after hospitalization . This affected one resident (Resident #74) of three residents reviewed for discharges. The facility census was 72. Findings include: Review of the closed record for Resident #74 revealed an admitted [DATE] with diagnoses including schizoaffective and mood affective disorder, unspecified intellectual disabilities, sexual dysfunction not due to a substance or known physiological condition, anxiety, insomnia, manic episodes, and assistance with personal care. Resident #74 was transferred to the hospital for an acute, inpatient psychiatric stay on 12/09/24 and did not return to the facility. Resident #74 had a legal guardian of person. Review of Resident #74's Minimum Data Set (MDS) 3.0 discharge return not anticipated assessment dated [DATE] revealed Resident #74 was modified independent for cognitive daily decision making, no delirium was noted. Resident #74 was positive for inattention, but no disorganized thinking or altered level of consciousness was noted. No hallucination noted but delusions were present. No physical behaviors towards others were displayed but verbal behaviors towards others were displayed daily. Rejection of care occurred daily and wandering occurred daily. Resident #74 was independent for eating, oral hygiene, dressing and toilet hygiene but needed supervision for showers. Resident #74 was independent with mobility such as rolling left and right in bed, sitting on the side of the bed and bed transfers but needed supervision for shower transfers. Resident #74 was independent to walk ten feet. Review of Resident #74's care plan, dated 11/18/24 revealed Resident #74 had behaviors related to a diagnosis of schizoaffective disorder, generalized anxiety disorder, unspecified mood disorder and manic episodes, dementia as evidenced by aggressively hugging and grabbing staff, pacing throughout facility without footwear, attempts to chase after staff, nonsensical statements verbally and written notes on a note pad, taking items from residents rooms, and refused medication. Intervention included offer and provide activities of interest to keep resident engaged, administer medication as ordered, engage resident in simple, structured activities that avoid overly demanding tasks, labs as ordered, notify physician of any significant change in resident's baseline cognitive status. Physical therapy, occupational therapy and speech therapy as needed. Refer to psychological/psychiatrist as needed. (continued on next page)

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	01/09/2025

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Situation Background, Assessment and Recommendation (SBAR) note dated 12/09/24 at 11:00 A.M. written by Nurse Practitioner (NP) #511 revealed Resident #74 had a change in condition with psychotic behaviors that started on 12/06/24 and have gotten worse. Worse behaviors included following staff, unable to re-direct regarding personal space. Resident refused to allow vitals to be taken. Treatment included as needed psychological medication and inpatient psychiatric stay. Resident #74 was admitted to the nursing home for long term needs. Mental status changes included new or worsening behavior symptoms, no functional status change, no gastrointestinal change, no urine change. Problems included increased psychotic behaviors due to inability to self-regulate, medication was ineffective, inappropriate level of care in facility. It was suggested Resident #74 transfer to the hospital. Guardian was notified of erratic behaviors, ineffective medication, inability to redirect, threatening others, intrusiveness, inappropriate touching and obsession with religion. The facility notified the guardian/mother of intention to send to the emergency department and not accept Resident #74 back since this was not an appropriate environment for Resident #74 to live in. Review of an interdisciplinary progress note dated 12/09/24 at 12:58 P.M. written by Licensed Practical Nurse (LPN)/Unit Manager (UM) #502 revealed Resident #74 stated he heard voices. Resident #74 stated the voices told him to do things he did not want to do. When asked if the voices were telling Resident #74 to harm himself or others, Resident #74 refused to answer and walked away. Review of the Social Services progress note dated 12/09/24 at 5:35 P.M. revealed the Director of Nursing (DON) and medical doctor planned for Resident #74 to transfer to the emergency room for psychological evaluation and treatment. It was reported that over the weekend Resident #74 had increased agitation, disruptive behavior in group settings and during church services. Resident #74 was placed on a one-on-one monitoring but too much stimulation according to social services. Resident #74 paced around common areas, did not respect others space, raised his voice, unpredictable and was not appropriate for this setting. The note indicated the facility was working with Resident #74's case manager to find alternative placement for him. Review of the interdisciplinary progress note dated 12/09/24 written by Registered Nurse (RN) #500 revealed Resident #74 disrupted church service by attempting to take the pastor's bible. Resident #74 stated he was the dark angel and you need to hear what I have to say. Resident was unable to be re-directed. Resident #74 stated don't you know who I am, we are all going to be murdered like the CEO of United Healthcare and there's nothing you can do to stop it. Resident #74 was approached by RN #500 and agreed to go in his room to watch football. Resident #74 was medicated with evening medication and as needed Zyprexa (antipsychotic medication) was provided. One-on-one continued. (continued on next page)

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	01/09/2025

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document Application for Emergency Admission (commonly known as pink slip which commits the resident involuntarily to the hospital), dated 12/09/24, revealed Resident #74 represented a substantial risk of physical harm to others manifested by evidence of recent homicidal or other violent behavior and would benefit from treatment in a hospital for his mental illness and was in need of such treatment as manifested by evidence of behavior that created a grave and imminent risk to substantial right of others or himself. The documented revealed Resident #74 was exhibiting threatening, impulsive behaviors since admission. Behaviors escalated into obsession about religious persecution and ideation and threats of physical harm. Resident #74 was intrusive, threatening towards other nursing home residents and had threatened to kill staff members and was physically capable of acting out these threats. Resident #74 experienced auditory hallucinations but would not reveal what the voices said. Resident #74 had attempted to leave the facility unattended by going to the exit doors and pushing on the doors. This created a substantial risk to his safety as well as others because the facility was located on a highway exit. Resident #74 required admission to an inpatient intensive psychiatric stay to improve the quality of life and to provide safety to the community. The Application for Emergency Admission was signed by the facility medical doctor # 513. Further review of Resident #74's medical record revealed no documentation after 12/09/24 that attempts had been made by the facility, the facility physician or nurse practitioner to collaborate with the hospital to assess Resident #74's mental health status to determine if he was stable for discharge back to the facility. Review of the facility document titled Immediate Involuntary Discharge, dated 12/09/24, revealed the document indicated it was hand delivered. The document indicated Resident #74 was notified he was immediately discharged because an emergency arose in which the safety of individuals in the home was endangered. Resident #74 had the right to request an impartial hearing at the facility concerning the proposed discharge. Resident #74 could challenge the discharge and request a hearing by sending in a request by resident or sponsor for a hearing within 30 days of receipt of the notice to the Ohio Department of Health Legal Services Office. If the resident or sponsor received the request within 10 days of the date of the notice, the facility would not discharge the resident prior to the hearing. Agency contact and Ombudsman contact information was provided. Interview on 01/08/25 at 8:18 A.M. with the hospital Supervisor of Behavior Health Social Work (SBHSW) #510 revealed Resident #74 was sent to the in-patient psychiatric unit for medication management and psychiatric stabilization and the current nursing facility he resided in would not take him back so he was still at the hospital while they tried to find him placement. The facility dropped off his belongings with a letter of immediate discharge in the bag which was not brought to the hospital or resident's attention at the time his belongings were dropped off at the hospital. SBHSW #510 stated Resident #74's mother and guardian stated to SBHSW #510 they did not receive an immediate discharge notice from the facility. SBHSW #510 stated the facility refused to perform an onsite visit of Resident #74. SBHSW #510 stated the worst of Resident #74's behaviors consisted of raised voice but was redirectable, there was no sexually inappropriate touching, or need for physical restraints while admitted to the hospital the past 29 days or a need for seclusion. Resident #74 took his medication, and the last time Resident #74 needed as needed medication was 01/06/25 per physician progress notes. SBHSW #510 stated at no time did the nursing facility physician or nurse practitioner reach out to the hospital social worker or physician regarding discharge needs. SBHSW #510 stated Resident #74 was stable and ready for discharge back to the nursing facility which he considered his home. (continued on next page)

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	01/09/2025

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/08/25 at 4:00 P.M. with Ombudsman #509 revealed the facility provided an immediate discharge notice to the hospital by placing it in his bag of belongings the facility dropped off. Ombudsman #509 stated Resident #74's mother wanted him to return to the same nursing facility upon discharge from the hospital because he needed assistance with medication. Ombudsman #509 stated the facility had not sent a liaison to the hospital to assess if Resident #74 was appropriate for re-admission to the facility. Interview on 01/08/25 at 4:32 P.M. with Resident #74's Legal Guardian #507 revealed as of 01/07/25 she was transitioned as legal guardian but Resident #74's mother still had input in Resident #74's care. Legal Guardian #507 stated the nursing facility stated they could not handle his care but in the hospital emergency room he did not display the same behaviors. Legal Guardian #507 stated the facility did not communicate when Resident #74 was admitted to the hospital therefore Resident #74's mother was not able to communicate with her son in the hospital. At no time had the facility physician or nurse practitioner reached out to Legal Guardian #507. Legal Guardian stated they would like Resident #74 back in the nursing facility. Interview on 01/09/25 at 9:47 A.M. with facility Nurse Practitioner (NP) #511 revealed the facility recommended a pink slip because Resident #74 was running up the hallway, threatening staff and felt residents were not safe. NP #511 verified she did not reach out the hospital to assess if Resident #74 was safe for discharge back to the facility. NP #511 stated as of her assessment , the nursing facility was meeting Resident #74's needs. NP #511 verified she did not speak with Legal Guardian #507 or Resident #74's mother regarding discharge from the facility. Interview on 01/09/25 at 10:37 A.M. with the facility Social Services (SS) #503 verified she did not speak with the hospital regarding if Resident #74 was stable or appropriate to return to the nursing facility, and the hospital only spoke with the Administrator. SS #503 verified the facility had been looking into placing him at another facility but Resident #74's guardian or mother did not receive a 30-day discharge notice or right to appeal, but instead was sent an emergent discharge notice. SS #503 verified she did not call the hospital for discharge planning or goals. Interview on 01/09/25 at 11:00 A.M. with the Administrator revealed the police were called regarding Resident #74's behaviors but no reports were made by the police because Resident #74 did not display behavior in front of the police. The Administrator stated the facility transportation person hand delivered the immediate discharge document to the resident in the emergency room . The immediate discharge notice was sent to the Guardian and mother by mail but not certified mail. The Administrator stated the hospital had stated Resident #74 was stable and the facility physician had not reached out to the hospital. The Administrator further stated the facility intention on 12/09/24 was to send Resident #74 to the hospital to stabilize and he would come back. She did not believe the hospital version of stable was the same version of stable as the nursing facility. The Administrator stated the facility could not take Resident #74 because the facility did not provide enough structure and there were some concerns for elopement. The Administrator stated Resident #74's mother did stated she wanted Resident #74 in a nursing home and to return back to his facility not back to his previous facilities. (continued on next page)

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	01/09/2025

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/25 at 11:35 A.M. with psychiatric NP #512 revealed Resident #74 displayed no physical abuse towards other resident , and Resident #74 did not make clear homicidal or suicidal indication during her assessment. Resident #74 needed one-on-one supervision because she felt he could be a threat to other residents. NP #512 stated the facility was capable of handling Resident #74's behavior. NP #512 did not recall that Resident #74 displayed violent or physical abuse to other residents in the nursing facility. NP #512 stated she assessed Resident #74 on her initial visit 11/11/24 and planned on visiting him every one to two months. NP #512 stated she was planned to see Resident #74 again but he was sent out to the hospital. NP #512 verified she did not speak with the hospital because she did not know he was sent to the hospital and felt Resident #74 could come back to the facility if Resident #74's mood and behavior was well managed such as 24/7 supervision. Interview on 01/09/25 at 12:29 P.M. with Unit Manager LPN # 502 revealed Resident #74 was not able to take his own medication and needed supervision with showers. Resident #74 did not physically assault another resident, and did not verbally or sexually assault another resident while admitted to the facility. Unit Manager LPN #502 verified she had not spoken with the hospital regarding Resident #74 status or visit Resident #74 on site. LPN #502 stated once Resident #74 stated he wanted to hurt himself but did not have a plan. Interview on 01/09/25 at 12:35 P.M. with Registered Nurse (RN) #500 revealed she worked the day Resident #74 was sent to the hospital. Resident #74 was hard to redirect, yelled and ran down the hallway. RN #500 stated Resident #74 never hit another resident or had an incident of sexual assault to another resident. Resident #74 could be verbally assaultive but could not provide an instance. Interview on 01/09/24 at 12:55 P.M. with Certified Nurse Assistant (CNA) #504 revealed the facility had educated staff on behavior management of residents and Resident #74 threatened staff but not residents. Resident #74 did not display physical or sexual assault to another resident. Interview on 01/09/25 at 1:12 P.M. with CNA #514 revealed the facility educated her on behavior management of residents and stated one time Resident #74 grabbed another resident's wheel chair but Resident #74 thought he was helping. Resident #74 did not physically hit another resident only threatened staff. Resident #74 did not sexually assault anyone but was verbally inappropriate. CNA #514 stated the facility was equipped to manage residents with behavior problems. Interview on 01/09/25 at 1:14 P.M. with Resident #74's mother revealed currently the hospital could not find a nursing facility for her son to live and the facility would not take her son back. The facility did not tell her Resident #74 was discharged . She stated she never received a 30-day discharge notice nor the immediate discharge notice. Resident #74's mother also stated at no time did she agree with the facility not to take her son back. Interview on 01/09/25 at 1:47 P.M. with the Director of Nursing (DON) revealed the immediate discharge letter was not sent by certified mail to Resident #74's mother or guardian therefore she had no proof the letter was sent. The DON also stated the facility did not plan to take Resident #74 back so he was discharged to the hospital with no anticipated return. (continued on next page)

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	01/09/2025

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/25 at 2:13 P.M. with hospital SBHSW #510 revealed on 12/10/24 Resident #74's mother stated she wanted her son to return to the facility and did not know her son was discharged from the facility. The immediate discharge letter stated it was hand delivered but it was not. On 12/11/24 the hospital social worker reached out to the facility stating Resident #74 was safe for discharge, but the facility responded Resident #74 was an immediate discharge and would not take Resident #74 back. On 12/12/24 the hospital reached out to the facility stating Resident #74's medication was changed and Resident #74 was compliant and able to be redirected. The hospital offered an on-site visit, but the facility responded, not able to accept patient. On 12/19/24 the hospital SW reached out to the facility, but the Administrator responded the denial was upheld by the facility. Resident #74 had stated to the hospital the facility was his home, and he wanted to return. SBHSW #510 further added the immediate discharge letter was not hand delivered to the resident. Resident #74 was in the emergency department on 12/09/24 at 5:46 P.M. and was transferred to the psychiatric unit on 12/10/24 at 1:10 A.M., and all of resident #74 's belongings were brought with him from the emergency department. On 12/10/24 at 2:55 P.M. hospital security notified her Resident #74's belongings were dropped off on the second floor of the hospital. When SBHSW #510 inspected the bag on the unit the immediate discharge letter was in the bag of resident's belongings. Review of facility policy titled Readmission to Facility dated 07/28/20 revealed if a resident was transferred to the hospital due to a resident's clinical or behavioral condition, the facility would evaluate the resident to determine if the resident still required the services of the facility and was eligible for Medicare skilled nursing facility or Medicaid nursing facility services. The facility would also determine the accurate status of a resident's condition to ensure the resident's needs were within the facilities scope of care. This deficiency represents non-compliance investigated under Complaint Number OH00160679.