

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/11/2025
NAME OF PROVIDER OR SUPPLIER  Arbors at Fairlawn The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011</b></p> <p>Based on observation, resident and staff interview, record review, and review of the facility policy, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) received assistance with bathing/showers. This affected four (Resident #9, #13, #38, and #46) of five residents reviewed for ADLs. The facility census was 73.</p> <p>Findings include:</p> <p>1. Record review for Resident #46 revealed an admitted [DATE]. Diagnoses included cerebral infarction, foot drop right foot, acquired absence of left fingers, muscle weakness and need for assistance with personal care.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #46 was cognitively intact. Resident #46 required supervision or touch assistants with bathing and tub/shower transfers.</p> <p>Review of the facility tasks revealed Resident #46 preferred showers every Tuesday and Friday. Record review from 02/26/25 through 03/11/25 of scheduled showers revealed Resident #46 did not receive or refuse the scheduled shower/bath on 02/28/25 or 03/07/25.</p> <p>Interview on 03/05/25 at 3:12 P.M. with Resident #46 stated the facility was shorthanded. Resident #46 stated a lot times he was scheduled for baths but did not receive it due to being staff shortage.</p> <p>Interview on 03/05/25 at 3:42 P.M. with Certified Nursing Assistant (CNA) #206 verified Resident #46 did not receive showers as scheduled and resident preference. CNA #206 stated there were staffing issues, and at times, the CNAs were unable to provide resident their showers because there was not enough staff.</p> <p>2. Record review for Resident #38 revealed an admitted [DATE]. Diagnoses included spondylosis with myelopathy cervical region, radiculopathy cervical region, muscle weakness, quadriplegia, and need for assistance with personal care.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. Resident 38 was dependent on staff for bathing and dressing.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan dated 09/18/23 for Resident #38 revealed Resident #38 had an ADL self-care performance deficit. Interventions included one-person assistance for bathing.</p> <p>Review of the facility tasks revealed Resident #38 preferred showers every Tuesday and Saturday. Record review from 02/15/25 through 03/11/25 of scheduled showers revealed Resident #38 did not receive the shower /bath on 02/15/25 or 03/01/25. There was no record of Resident #38 refusing on 02/15/23 or 03/01/25. All documentation of completed baths revealed Resident #38 only received bed baths.</p> <p>Interview on 03/04/25 at 3:45 P.M. with Resident #38 stated he was not getting his showers like he should. Resident #38 stated there were days they switch staff, his showers were Tuesdays and Saturdays but they will just do a bed bath when he wants a shower because it was easier for staff to do a bed bath. Resident #38 stated, I feel forced at times to do a bed bath but depending on the nursing aide, some don't clean you up as well as others.</p> <p>Interview on 03/04/25 at 4:01 P.M. with Certified Nursing Assistant (CNA) #224 verified Resident #38 did not receive showers as scheduled. CNA #224 explained there was not enough staff to provide residents with a shower during her shift. CNA #224 stated she may have to do bed baths for the residents instead of showers because there was not enough time.</p> <p>3. Record review for Resident #9 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), obstructive and reflux uropathy, abnormalities of gait and mobility, muscle weakness and need for assistance with personal care.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact. Resident #9 required substantial/maximal assistance with bathing and personal hygiene.</p> <p>Review of the facility tasks revealed Resident #9 preferred showers on Friday and Tuesday. Record review from 02/26/25 through 03/11/25 of scheduled showers revealed Resident #9 did not receive or refuse a shower/bath on 03/07/25. Documentation revealed all other bed baths/showers were given as scheduled.</p> <p>Interview and observation on 03/04/25 at 4:07 P.M. with Resident #9 revealed the resident was lying in bed in his pajamas. Resident #9's hair was very oily, Resident #9 had a strong body odor. His finger nails were dirty and uneven. Resident #9 stated he was not getting his baths as scheduled.</p> <p>Interview and observation on 03/05/24 at 10:50 A.M. with Certified Nursing Assistant (CNA) #241 confirmed Resident #9 had a foul odor.</p> <p>4. Record review for Resident #13 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left nondominant side, abnormalities of gait and balance and need for assistance with personal care.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 had impairment on one side of the upper and lower extremity, required set up or clean up assistance with toileting hygiene, supervision or touch assistance with showers and partial/moderate assistance with transfers and dressing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility tasks revealed Resident #13 preferred showers every Thursday and Sunday. Record review from 02/15/25 through 03/11/25 of scheduled showers revealed Resident #13 did not receive/refuse a shower/bath on 02/16/25, 02/27/25, 03/06/25, or 03/09/25.</p> <p>Interview on 03/11/25 at 1139 A.M. with Resident #13 confirmed he did not receive showers every Thursday and Sunday as scheduled consistently and stated did not receive a shower on the previous Sunday (03/09/25) because the staff told him they were short staffed.</p> <p>Interview on 03/11/25 at 2:37 P.M. with the Director of Nursing (DON) confirmed Resident #13 did not receive his shower or bed bath the previous Sunday and stated the CNA who was assigned to him was required to float between both ends of the facility.</p> <p>Review of the facility policy titled, Activities of Daily Living revised 12/28/23 revealed a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00161403.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on observations, staff interviews, record review, and review of the facility policy, the facility failed to ensure fall interventions were in place for a resident with a history of falls and was a fall risk. This affected one (Resident #68) of three residents reviewed for falls. The facility census was 73.</p> <p>Findings include:</p> <p>Record review for Resident #68 revealed an admitted [DATE]. Diagnoses included dementia, anxiety disorder, history of falling, unsteadiness on feet, muscle weakness, and need for assistance with personal care. Review of the census revealed Resident #68 moved from 100 hall to 200 hall on 12/11/24.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #68 was moderately cognitively impaired. Resident #68 used a wheelchair for mobility, required supervision or touching assistance with personal hygiene, transfers, and toilet transfers. Resident #68 had no falls since prior assessment.</p> <p>Review of the care plan for Resident #68 updated 11/13/23 revealed Resident #68 was at risk for falls related to cognitive impairment, dementia, anxiety, depression, vision, incontinence, decreased safety awareness, and history of falls including fall with fracture. Interventions included hipsters as tolerated dated 09/24/23, call light within reach dated 09/24/23, call before fall sign in room dated 09/24/23, and remove the wheelchair from the room while in bed dated 09/24/23, and the resident to be up in common area as tolerated dated 11/25/24.</p> <p>Review of the fall risk evaluation dated 11/09/24 revealed Resident #68 had a score of eight. The evaluation did not explain what level the score of eight was.</p> <p>Review of the fall history for Resident #68 from 11/01/24 through 03/05/25 revealed Resident #68 had a fall on 11/05/24, 11/10/24, 11/14/24, 01/02/25, 01/26/25 (injuries included bleeding from previous skin tear left forearm), 02/05/25, 02/21/25 (injuries included obtained a skin tear to the right leg), and 02/28/25 (injuries included skin tear to the right arm).</p> <p>Observation on 03/05/25 at 8:52 A.M. revealed Resident #68 was lying in bed awake. Observation revealed Resident #68's wheelchair was next to her bed. There was no call before you fall sign, and the call light was dangling between the mattress and transfer bar onto the floor.</p> <p>Observation on 03/05/25 at 8:54 A.M. with Medication Technician #203 confirmed Resident #68 was awake, lying in bed. Resident #68's call light was not within reach, there was no sign in the room to remind Resident #68 to call before you fall, and the wheelchair was next to the bed. Medication Technician #68 verified Resident #68 had frequent falls and she kept her wheelchair by the bed. Medication Technician #203 then left the room without moving the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 03/05/25 at 9:04 A.M. with Certified Nursing Assistant (CNA) #202 stated she will assist Resident #68 up out of bed around 10:00 A.M. CNA #202 stated Resident #68 was up once this morning and put herself back to bed. At 9:10 A.M., CNA #202 stated she was ready now to get Resident #68 up. CNA #202 assisted Resident #68 to the wheelchair then transferred Resident #68 to the toilet. Resident #68 did not have hipsters on. CNA #202 assisted Resident #68 with peri care, dressing, and transferred her back to her wheelchair. CNA #202 never offered to assist Resident #68 to put on her hipsters. CNA #202 then transferred Resident #68 back to her bed. CNA #202 then asked Resident #68 if she was going to use her wheelchair or walker. Resident #68 replied her walker. CNA #202 said, Ok, well then I will leave it right here next to your bed. CNA #202 left the wheelchair and walker near Resident #68 before exiting the room. CNA #202 stated when Resident #68 was on the 100-hall, she wore hipsters but has not worn any while on the 200-hall. CNA #202 returned to Resident #68's room and verified Resident #68 did not have hipsters available in her room. CNA #202 stated she was unsure why Resident #68 did not wear hipsters anymore. CNA #202 again left the wheelchair and walker near Resident #68 before exiting the room.</p> <p>Interview on 03/11/25 at 2:37 P.M. with the Director of Nursing (DON) confirmed Resident #68 was at a high risk for falls. The DON confirmed Resident #68's fall interventions still included hipsters as tolerated, the call light within reach, a call before fall sign in room and remove the wheelchair from her reach while she was in bed. The DON stated she also put into place that Resident #68 was to be up in the common area when was awake due to her frequent falls.</p> <p>Review of the facility policy titled Accidents and Supervision revised 12/27/23 revealed each resident will be assessed for accident risk and will receive care in accordance with their individualized care plan.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00162486.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on observation, resident and staff interview, record review, and review of the facility policy, the facility failed to ensure the residents received timely incontinence care. This affected three (Residents #9, #49, and #56) of three residents reviewed for incontinence care. The facility census was 73.</p> <p>Findings include:</p> <p>1. Record review for Resident #9 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), obstructive and reflux uropathy, abnormalities of gait and mobility, muscle weakness and need for assistance with personal care.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact. Resident #9 had an indwelling catheter and was always incontinent of bowel. Resident #9 used a wheelchair for mobility, required substantial/maximum assistance with toileting hygiene, lower body dressing, partial/moderate assistants for bed mobility, and dependent on staff with transfers.</p> <p>Review of the care plan for Resident #9 dated 01/09/25 revealed Resident #9 had episodes of bowel incontinence related to benign prostatic hyperplasia, generalized weakness and pain. Interventions included to assist resident with toileting needs and check at regular intervals and change as needed.</p> <p>Observation and interview on 03/05/25 at 9:43 A.M. revealed Resident #9 was lying in bed. Resident #9 had an odor of stool. Resident #9 confirmed he had a bowel movement (BM) but they have not changed him yet.</p> <p>Observation on 03/05/25 at 10:50 A.M. with Certified Nursing Assistant (CNA) #241 and #278 of incontinence care for Resident #9 revealed Resident #9 was still in bed. CNA #241 confirmed she was Resident #9's primary CNA and stated she had not been in yet on this day to change Resident #9. CNA #241 stated their shift started at 6:00 A.M. Observation of incontinence care revealed Resident #9's had a large BM. CNA #241 confirmed she never checked on Resident #9 for incontinence care needs until the surveyor requested to observe incontinence care for Resident #9.</p> <p>2. Record review for Resident #49 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, muscle weakness and need for assistance with personal care.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was moderately cognitively impaired. Resident #49 used a wheelchair for mobility, was always incontinent of bowel and bladder, required substantial/maximal assistance with toileting hygiene, personal hygiene, upper and lower body dressing and bed mobility.</p> <p>Review of the care plan dated 10/30/23 revealed Resident #49 had an activities of daily living (ADL) self-care performance deficit. Interventions included one-person assistance for toileting, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan dated 10/30/23 revealed Resident #49 had incontinent episodes of bladder/bowel related to debility and impaired mobility. Interventions included to assist resident with toileting needs, and check resident at regular intervals and change as needed.</p> <p>Observation on 03/05/25 at 11:22 A.M. of incontinence care for Resident #49 completed by Certified Nursing Assistant (CNA) #241 revealed Resident #49's brief was saturated with urine and bowel movement (BM). Resident #49's buttocks was red and the skin on the buttocks and back was creased and wrinkled from the wrinkled bedding she had been lying on. CNA #241 stated this was the first time on this shift she had checked Resident #49 for incontinence needs due to being busy with other residents.</p> <p>3. Record review for Resident #56 revealed an admission day of 05/15/23. Diagnoses included adult failure to thrive, overactive bladder, and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact. Resident #56 used a walker and a wheelchair for mobility. Resident #56 was frequently incontinent of bowel and bladder. Resident #56 required supervision or touch assistance for toileting hygiene, partial/moderate assistance for upper body dressing, substantial/maximal assistance for lower body dressing, and partial moderate assistance for personal hygiene.</p> <p>Review of the care plan dated 09/20/23 revealed Resident #56 had an activity of daily living (ADL) self-care performance deficit. Interventions included supervision with ambulation, and one person assistant with toileting and personal hygiene.</p> <p>Review of the care plan dated 05/06/24 revealed Resident #56 had episodes of functional bowel and bladder incontinence. Interventions included to assist the resident with toileting needs, and check resident at regular intervals and change as needed.</p> <p>Observation on 03/05/25 at 11:38 A.M. of incontinence care for Resident #56 completed by Certified Nursing Assistant (CNA) #241 revealed Resident #56 was sitting up in her bed. Resident #56 had a hospital gown on with one gown in the front and an additional gown in the back covering her back side. Resident #56 stated she was saturated with urine and had been waiting all day to be changed. Resident #56 had a foul odor of urine. Observation revealed CNA #241 ambulated with Resident #56 using a rollator to the bathroom. Resident #56's gown was saturated with urine covering the entire back side. The sheet and bed pad where Resident #56 was sitting was also saturated with urine. Resident #56's saturated brief was bulging with urine. CNA #241 confirmed this was the first time today getting to Resident #56 to assist with incontinence care.</p> <p>Interview on 03/05/25 at 11:49 A.M. with the Director of Nursing (DON) stated residents were checked and changed per plan of care and every two hours. The DON confirmed day shift started at 6:00 A.M. until 2:00 P. M. The DON stated by 8:30 A.M., every resident should be seen, checked and changed if needed.</p> <p>Review of the facility policy titled Incontinence revised 10/26/23 revealed based on a resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00161403.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on observation, resident and staff interview, record review, and review of the facility policy, the facility failed to provide sufficient staff to ensure the residents received timely assistance with showers/bathing, incontinence care, dressing, personal hygiene, and changing of soiled sheets. This affected six of six residents (Resident #9, #13, #38, #46, #49, and #56) reviewed for sufficient staffing and had the potential to affect all residents residing at the facility. The facility census was 73.</p> <p>Findings include:</p> <p>1. Record review for Resident #46 revealed an admitted [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #46 was cognitively intact. Resident #46 required supervision or touch assistants with bathing and tub/shower transfers.</p> <p>Review of the facility tasks revealed Resident #46 preferred showers every Tuesday and Friday. From 02/26/25 through 03/11/25, Resident #46 did not receive or refuse the scheduled shower/bath on 02/28/25 or 03/07/25.</p> <p>Interview on 03/05/25 at 3:12 P.M. with Resident #46 stated the facility was shorthanded. Resident #46 stated a lot times he was scheduled for baths but did not receive it due to being staff shortage.</p> <p>Interview on 03/05/25 at 3:42 P.M. with Certified Nursing Assistant (CNA) #206 verified Resident #46 did not receive showers as scheduled and resident preference. CNA #206 stated there were staffing issues, and at times, the CNAs were unable to provide resident their showers because there was not enough staff.</p> <p>2. Record review for Resident #38 revealed an admitted [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. Resident 38 was dependent on staff for bathing and dressing.</p> <p>Record review from 02/15/25 through 03/11/25 of scheduled showers revealed Resident #38 did not receive the shower /bath on 02/15/25 or 03/01/25. There was no record of Resident #38 refusing on 02/15/23 or 03/01/25. All documentation of completed baths revealed Resident #38 only received bed baths.</p> <p>Interview on 03/04/25 at 3:45 P.M. with Resident #38 stated he was not getting his showers like he should. Resident #38 stated there were days they switch staff, his showers were Tuesdays and Saturdays but they will just do a bed bath when he wants a shower because it was easier for staff to do a bed bath. Resident #38 stated, I feel forced at times to do a bed bath but depending on the nursing aide, some don't clean you up as well as others.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 03/04/25 at 4:01 P.M. with Certified Nursing Assistant (CNA) #224 verified Resident #38 did not receive showers as scheduled. CNA #224 explained there was not enough staff to provide residents with a shower during her shift. CNA #224 stated she may have to do bed baths for the residents instead of showers because there was not enough time.</p> <p>3. Record review for Resident #13 revealed an admitted [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively intact and required supervision or touch assistance with showers and partial/moderate assistance with transfers and dressing.</p> <p>Record review from 02/15/25 through 03/11/25 of scheduled showers revealed Resident #13 did not receive/refuse a shower/bath on 02/16/25, 02/27/25, 03/06/25, or 03/09/25.</p> <p>Interview on 03/11/25 at 1139 A.M. with Resident #13 confirmed he did not receive showers every Thursday and Sunday as scheduled consistently and stated did not receive a shower on the previous Sunday (03/09/25) because the staff told him they were short staffed.</p> <p>4. Record review for Resident #9 revealed an admitted [DATE]. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact. Resident #9 required substantial/maximal assistance with bathing and personal hygiene. Resident #9 had an indwelling catheter and was always incontinent of bowel.</p> <p>4a. Record review from 02/26/25 through 03/11/25 of scheduled showers revealed Resident #9 did not receive or refuse a shower/bath on 03/07/25. Documentation revealed all other bed baths/showers were given as scheduled.</p> <p>Interview and observation on 03/04/25 at 4:07 P.M. with Resident #9 revealed the resident was lying in bed in his pajamas. Resident #9's hair was very oily, Resident #9 had a strong body odor. His finger nails were dirty and uneven. Resident #9 stated he was not getting his baths as scheduled.</p> <p>Observation and interview on 03/05/25 at 9:43 A.M. revealed Resident #9 was lying in bed. Observation revealed Resident #9's sheet and blanket was wet with a large spill. Resident #9 stated he spilled his whole cup of coffee when he was eating breakfast. Resident #9 stated he was not burned from the coffee but confirmed his blanket and sheet was wet.</p> <p>Observation and interview on 03/05/25 at 10:50 A.M. with Certified Nursing Assistant (CNA) #241 and #278 verified Resident #9 was still in bed. Resident #9 was still covered with the sheet and blanket that had the coffee spilled onto it at breakfast time. CNA #241 confirmed she was Resident #9's primary CNA and stated Resident #9 spilled his coffee on the blanket and sheet he was covering up with. CNA #241 confirmed she was aware of the spill but did not have time to assist him with any morning care until now stating she was busy with other residents. CNA #241 stated she still had three residents to go after Resident #9 for their first set of rounds of the day to check and change them. CNA #241 stated she started her shift at 6:00 A.M. and confirmed she had not been in yet on this day to provide morning care for Resident #9.</p> <p>4b. Observation and interview on 03/05/25 at 9:43 A.M. revealed Resident #9 was lying in bed. Resident #9 had an odor of stool. Resident #9 confirmed he had a bowel movement (BM) but they have not changed him yet.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/11/2025
NAME OF PROVIDER OR SUPPLIER  Arbors at Fairlawn The		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 03/05/25 at 10:50 A.M. with Certified Nursing Assistant (CNA) #241 and #278 of incontinence care for Resident #9 revealed Resident #9 was still in bed. CNA #241 confirmed she was Resident #9's primary CNA and stated she had not been in yet on this day to change Resident #9. CNA #241 stated their shift started at 6:00 A.M. Observation of incontinence care revealed Resident #9's had a large BM. CNA #241 confirmed she never checked on Resident #9 for incontinence care needs until the surveyor requested to observe incontinence care for Resident #9.</p> <p>5. Record review for Resident #49 revealed an admitted [DATE]. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was moderately cognitively impaired. Resident #49 was always incontinent of bowel and bladder, required substantial/maximal assistance with toileting hygiene.</p> <p>Observation on 03/05/25 at 11:22 A.M. of incontinence care for Resident #49 completed by Certified Nursing Assistant (CNA) #241 revealed Resident #49's brief was saturated with urine and bowel movement (BM). Resident #49's buttocks was red and the skin on the buttocks and back was creased and wrinkled from the wrinkled bedding she had been lying on. CNA #241 stated this was the first time on this shift she had checked Resident #49 for incontinence needs due to being busy with other residents. CNA #241 stated Resident #49 should have been up out of bed a long time ago. Resident #49 asked CNA #241 if today was her shower day. CNA #241 stated it was and asked Resident #49 if she wanted it today or tomorrow because she (CNA #241) had not had her lunch yet and she was supposed to take it at 11:30 A.M. CNA #241 stated to Resident #49 that she was sorry, she did not have time to do it today but promised she would do it tomorrow. Resident #49 agreed to take the shower the next day so CNA #241 could go to lunch. Resident #56 was Resident #49's roommate. While completing care for Resident #49, CNA #241 said to Resident #56 she would get to her as soon as she was done with Resident #49. CNA #241 then stated to Resident #56, she needed to take her break (it was now 11:32 A.M.) at 11:30 A.M. and asked Resident #56 (while still working with Resident #49) if she wanted to wait until after lunch to get changed. Resident #56 shouted, No, I do not want to sit here wet all day</p> <p>6. Record review for Resident #56 revealed an admission day of 05/15/23. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact. Resident #56 was frequently incontinent of bowel and bladder. Resident #56 required supervision or touch assistance for toileting hygiene.</p> <p>Observation on 03/05/25 at 11:38 A.M. of incontinence care for Resident #56 completed by Certified Nursing Assistant (CNA) #241 revealed Resident #56 was sitting up in her bed. Resident #56 had a hospital gown on with one gown in the front and an additional gown in the back covering her back side. Resident #56 stated she was saturated with urine and had been waiting all day to be changed. Resident #56 had a foul odor of urine. Observation revealed CNA #241 ambulated with Resident #56 using a rollator to the bathroom. Resident #56's gown was saturated with urine covering the entire back side. The sheet and bed pad where Resident #56 was sitting was also saturated with urine. Resident #56's saturated brief was bulging with urine. CNA #241 confirmed this was the first time today getting to Resident #56 to assist with incontinence care.</p> <p>Interview on 03/05/25 at 11:49 A.M. with the Director of Nursing (DON) stated residents were checked and changed per plan of care and every two hours. The DON confirmed day shift started at 6:00 A.M. until 2:00 P. M. The DON stated by 8:30 A.M., every resident should be seen, checked and changed if needed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Arbors at Fairlawn The		STREET ADDRESS, CITY, STATE, ZIP CODE  575 S Cleveland Massillon Road Fairlawn, OH 44333	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00161403.</p>		