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	05/12/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record reviews and interviews with staff the facility failed to notify Resident #90's physician and daughter of notification of changes. This affected one resident of three reviewed for notifications of change. The census was 80. Findings include: Review of the closed medical record for Resident #90 revealed an initial admitted [DATE] and re-admitted [DATE] with diagnoses including chronic obstructive pulmonary disorder, diabetes and congestive heart failure. Resident #90 was discharged on [DATE]. Review of the profile tab in the electronic medical record revealed Resident #90 was listed first as his own responsible party then his daughter as the second contact. Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #90 was cognitively intact. He was independent with chair to chair transfers. Review of Resident #90's progress note on 02/05/25 at 8:30 P.M. revealed Resident #90 wanted to go to the hospital. The resident was sent to the emergency room (ER). Resident was his own responsible party. There was no evidence his daughter was notified. Review of Resident #90's progress note on 03/16/25 at 9:06 A.M., 03/17/25 at 8:52 A.M., 03/18/25 at 9:38 A.M. and 12:38 P.M. and 03/19/25 at 7:41 A.M. revealed Resident #90 refused either treatments such as dialysis or vitals signs, and/or medications. There was no evidence Resident #90's physician or daughter was notified of the refusals. Review of Resident #90's progress note on 03/21/25 at 2:58 P.M. revealed Resident #90 was sent to the ER. There was no evidence Resident #90's daughter was notified. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #90's progress notes dated 04/18/25 at 11:49 P.M. and authored by Licensed Practical Nurse (LPN) #265 revealed the day nurse reported Resident #90 signed himself out on an LOA. The resident had not returned yet. Resident #90's note dated 04/19/25 at 4:03 A.M. authored by LPN #265 indicated LOA. There was no evidence Resident 90's physician or daughter were notified of the resident not returning from LOA. Review of two progress notes dated 04/19/25 at 9:30 A.M. authored by LPN #211 stated Resident #90's daughter called the facility stating he passed away and the second note revealed LPN #211 informed the Director of Nursing and the physician assistant. Interview on 05/12/25 at 3:53 P.M. with the Director of Nursing (DON) confirmed there were inconsistencies in when the facility notified Resident #90's physician and daughter related to hospitalization , refusals of treatments, and not returning from LOA. The deficient practice was corrected on 04/24/25 when the facility implemented the following corrective actions: On 04/19/25 the DON suspended LPN #265 and gave her a final written warning. LPN #265 was educated by the DON on notifications of refusals of medications and treatments. On 04/20/25 the DON audited all residents progress notes, Medication Administration Records (MARs) and Treatment Administration Records (TARs), new orders and alerts for the past seven days for proper notifications of refusals or other changes. The DON or designee educated all nurses on notification on refusals of medications and treatments by 04/22/25. All residents' notes, MARs, TARs, orders and alerts reviewed at clinical meeting by the team (DON, Administrator, Unit Manager, MDS nurse and SSD) Monday through Friday for proper notifications of refusals and other changes. DON/Designee will interview five nurses weekly for four weeks on documenting refusals and notifications. Ad Hoc QAPI meeting was held on 04/21/25 including the Medical Director, Administrator and DON. Interdisciplinary team will identify residents who refuse treatments and medications or require notifications and ensure they are completed timely during the clinical meeting Monday through Friday. Results of audits will be reviewed at QAPI meeting for one month with revisions to the plan or changes deemed necessary by the team. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Notification of Changes, revised 08/29/25 revealed the facility should ensure to promptly inform the resident, physician and notify the resident representative when there is a change requiring notification such as but not limited to: accidents, significant changes like deterioration in health, mental or psychosocial status or a circumstance requiring a need to alter treatment, exacerbation of a chronic condition or a transfer or discharge from the facility. When a resident is mentally competent, a designated family member should be notified of significant changes because the resident may not be able to notify them personally. This deficiency represents non-compliance investigated under OH00165215.

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F 0689 Level of Harm - Minimal harm or potential for 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** 42734 Based on record reviews and interview, the facility failed to ensure Resident #90's safety after not returning timely after a leave of absence (LOA). This affected one resident (Resident #90) of three residents reviewed for LOA's. The census was 80. Findings include: Review of closed medical record for Resident #90 revealed an initial admitted [DATE] and re-admitted [DATE] with diagnoses included chronic obstructive pulmonary disorder, diabetes and congestive heart failure. Resident #90 was discharged on [DATE]. Review of the profile tab in the electronic medical record revealed Resident #90 listed first as his own responsible party then his daughter as the second contact. Review of the care plan dated [DATE] revealed the facility would honor Resident #90's preferences including leaving the building unsupervised and traveling throughout the community in his powerchair via public transport. Review of the elopement assessment dated [DATE] for Resident #90 revealed he was not at risk for elopement. Review of Resident #90's [DATE] orders revealed an order for LOA independently without medication effective [DATE]. Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #90 was cognitively intact and independent with chair to chair transfers. Review of Resident #90's LOA sheets from [DATE] through [DATE] revealed he returned prior to midnight of same day for all of his outings. Review of entry on [DATE] revealed he signed out at 11:55 A.M. with Barberton as his destination. Review of Resident #90's progress notes dated [DATE] at 11:49 P.M. and authored by Licensed Practical Nurse (LPN) #265 revealed the day nurse reported Resident #90 signed himself out on an LOA. The resident had not returned yet. Resident #90's note dated [DATE] at 4:03 A.M. authored by LPN #265 indicated LOA. Review of two progress notes dated [DATE] at 9:30 A.M. authored by LPN #211 stated Resident #90's daughter called the facility stating he passed away and the second note revealed LPN #211 informed the Director of Nursing and the physician assistant. Review of a progress note dated [DATE] at 4:21 P.M. authored by DON revealed she had spoken to the hospital case manager who stated Resident #90 arrived from the grocery store to the emergency room at 3:16 P.M. on [DATE]. He had expired from acute pulmonary arrest at 10:45 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:14 P.M. with LPN #211 revealed she worked on [DATE]. When she learned Resident #90 was not back yet she reviewed the LOA book to see he logged out on [DATE] at 11:55 A.M. She stated she tried to call Resident #90's cell phone between 9:00 A.M. and 9:30 A.M. but there was no voicemail. About the same time the, Resident #90's daughter called the facility to notify them of his death. LPN #211 described Resident #90's routine LOA as taking public transport to nearby city via public transportation where he hung out with friends in stores of an area shopping plaza. She stated he had mentioned to her one time to contact the women at the one store if they needed to find him. She stated he would stay out past 10:00 P.M. some nights but had always returned before midnight. LPN #211 stated she was unsure if LPN #265 tried to call Resident #90's cell phone the night he didn't return, but her expectation was that he would be called. She was uncertain if management was notified on [DATE] that he had not returned from his LOA. Interview on [DATE] at 2:33 P.M. with Social Service Designee (SSD) #258 revealed she felt Resident #90 was going to do what he wanted. She stated her expectation was a call be made to the missing resident and a search take place. She was uncertain of what his care plan was at the time of interview. Interview on [DATE] at 2:53 P.M. with the Administrator revealed Resident #90 had been told in the past to be back in the facility by midnight. Her expectation would be to call his cell phone then call the hospitals and to search grounds in case his motorized wheelchair battery died . Interview on [DATE] at 3:53 P.M. with the Director of Nursing (DON) revealed her expectation, if a resident was not back as anticipated by midnight, staff were to call resident's cell phone, call the hospitals and to start looking for him. She stated LPN #265 had texted her at almost midnight on [DATE] that Resident #90 did not return from his LOA, and DON stated to call his cell phone. When she did not get a response DON texted and told her to call the hospitals. DON's expectation was to start searching for him if not at hospital. DON stated she fell back asleep but had no messages from the facility on her phone when she got up on [DATE]. She was not sure if he returned yet or not. DON called the facility around 9:00 A.M. and spoke to LPN #211 who told her Resident #90 had not returned. Within five minutes of their conversation LPN #211 had learned through a phone call from the hospital and a separate call from the daughter he had been at a local hospital where he passed away. The DON discovered LPN #265 never called the hospitals or daughter. LPN #265 was suspended and given a final written warning. Interview on [DATE] at 4:15 P.M. with LPN #265 revealed she worked on [DATE] from 6:00 P.M. to 6:00 A.M. She stated she called Resident #90's cell phone with no response. She stated she texted the DON who responded telling her to call the hospitals. She stated she did not call the hospitals because she was too busy. She stated she figured dayshift would do it. LPN #265 stated Resident #90 had always come back before midnight from his LOAs. Interview on [DATE] at 4:40 P.M. with DON revealed LPN #265 told her she didn't call the hospitals because she figured the hospital would call the facility. Review of the facility policy titled Resident Appointment/Outing including overnights (not transfer/discharge), dated [DATE] revealed the policy was to assure resident safety and staff knowledge of resident's whereabouts by signing out on the log. Residents should note destination and approximate time of return. The policy stated it should be documented in the medical record what time the resident left, with who and other pertinent information. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00165215.