| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365718 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Streetsboro | 1645 Maplewood Dr<br>Streetsboro, OH 44241 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365718 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Streetsboro | 1645 Maplewood Dr<br>Streetsboro, OH 44241 |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review and review of Self-Reported Incident (SRI) #261109, the facility failed to treat Resident #19 with respect and dignity. This affected one (Resident #19) of four residents reviewed for resident rights. The facility census was 70. Findings include:Review of the medical record for Resident #19 revealed an admission date of 01/31/17 with diagnoses including diabetes mellitus type two, generalized anxiety disorder, osteoarthritis and pain of the right knee, personality disorder, violent behavior, and major depressive disorder. Review of Resident #19's plan of care reviewed 10/29/24 revealed the resident used a wheelchair for self-propelling, required one person assist with transfers, and had behaviors including refusals of incontinence care and yelling or using profanity towards staff. Review of the Quarterly Minimum Data Set (MDS) assessment completed 06/05/25 revealed no cognitive impairment. Review of SRI tracking #261109 dated 06/02/25 revealed an allegation of physical abuse was reported to administration by Resident #72 who witnessed staff roughly transfer Resident #19 on 05/31/25 into a wheelchair. Video evidence indicated the incident actually occurred on 05/30/25 at 9:17 P.M. and involved Certified Nursing Assistant (CNA) #300 and Licensed Practical Nurse (LPN) #301. Resident #19 was lying on a common area couch and had an episode of incontinence but was resistive to return to her room via the wheelchair for personal care. CNA #300 made attempts and reapproach the resident several times for approximately one hour then asked LPN #301 for advice. Both CNA #300 and LPN #301 transferred Resident #19 together arm-in-arm standing on each of the resident's sides into the wheelchair without foot pedals. The resident would not hold her legs up so the two staff members tipped the wheelchair backwards, and CNA #300 pushed Resident #19 back to her room while LPN #301 held her legs. Review of the written witness statement for LPN #301 dated 06/03/25 indicated CNA #300 reported Resident #19 was incontinent on the couch and refused to get cleaned up saying to leave her alone, so they both tried to under arm her placing her in the chair, but it was difficult. The resident ended up at the tip of the wheelchair so CNA #300 leaned the wheelchair backwards to get Resident #19 into the back of the chair, but the resident was combative trying to kick and jump out of the chair, so LPN #301 grabbed her legs to prevent the resident from hurting herself and they got her back to the room for care. Review of the written witness statement for CNA #300 dated 06/02/25 indicated Resident #19 was incontinent on the couch so the aide tried to get her to go back to her room to get cleaned up but refused. LPN #301 came over to help. We sat the resident up, got on each side of her and picked her up and placed her into the wheelchair. CNA #300 tried to push Resident #19 to her room, but her feet were twisting into the wheels, so the aide held the wheelchair backwards and looked to LPN #301 for direction. LPN #301 told the aide to take Resident #19 back to her room just like that (tipped backwards), and when the resident got back to the room, she swung her nails toward the aide who decided to let Resident 19 cool down before care was provided. Review of a performance improvement form dated 06/06/25 for LPN #301 indicated the nurse was discharged from employment due to advising CNA #300 to transport Resident #19 while tipped backwards in a wheelchair on two wheels and then assisting by holding the resident's legs which was observed on video. Review of a performance improvement form dated 06/06/25 for CNA #300 indicated the aide was discharged from employment due to tipping Resident #19 backwards in the wheelchair onto two wheels and transporting her back to her room which was observed on video. Interview on 07/22/25 at 1:03 P.M. with Administrator verified the above incident findings. The deficient practice was corrected on 06/06/25 when the facility implemented the following corrective actions: CNA #300 and LPN #301 were suspended on 06/02/25 by the Director of Nursing (DON). Staff statements from those involved were obtained by DON on 06/02/25. On 06/02/25 an order was written for psychiatric/psychological services to consult Resident #19 on next facility visit. Resident skin assessments were completed post incident by floor nurses with no new skin issues identified. Resident #19's responsible party and nurse practitioner were notified on 06/02/25 by the DON. Social service designee completed psychosocial visits with Resident #19 on 06/04/25, 06/05/25 and 06/06/25 with no changes from baseline. All residents were interviewed and those who could not be interviewed received comprehensive skin assessments by licensed nurses by 06/04/25 with no variances noted. A root cause analysis was completed on 06/05/25 by the interdisciplinary team (IDT). Police were notified by Regional Director of Clinical Services (RDCS) #303 on 06/05/25 and report completed. All staff were educated by RDCS or designee by 06/06/25 regarding facility abuse policy, including timely reporting |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365718 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Streetsboro | 1645 Maplewood Dr<br>Streetsboro, OH 44241 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365718 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Streetsboro | 1645 Maplewood Dr<br>Streetsboro, OH 44241 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, and review of the facility policy, the facility failed to maintain a clean and sanitary environment. This affected two (Residents #6 and #67) of 14 residents reviewed for environment and had the potential to affect all residents residing in the facility. The facility census was 70. Findings include: 1. Observation on 07/21/25 at 9:54 A.M. revealed Resident #6 in a wheelchair next to the bed watching television. The room had a distinct odor of urine. The bed covers were pulled away which exposed a wet soiled incontinence pad. The edges of the soiled area were dried and yellowish-brown in color. There were six gnats crawling upon the wet part of the soiled area and two gnats flying above it. Nearby on the floor just outside the bathroom was a small pile of wet soiled clothes. Across the room from the bed near the wall was soiled linen including a towel and washcloth. Interview with Resident #6 at the time of the observation who complained about the bed and indicated having been up in the wheelchair for a long time without it being cleaned up. Interview on 07/21/25 at 10:01 A.M. with Certified Nursing Assistant (CNA) #214 confirmed the observation in Resident #6's room and verified night shift had gotten Resident #6 up and left it that way but had not had an opportunity to fix it yet although it had been a few hours since then. Review of the medical record for Resident #6 revealed an admission date of 07/25/19 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, congestive heart failure and diabetes mellitus type two. The Annual Minimum Data Set (MDS) assessment completed 06/10/25 indicated no cognitive impairment. The plan of care reviewed 06/27/25 specified Resident #6 required one to two staff assistance with all activities of daily living (ADL) and was incontinent of bowel and bladder. 2. Observation on 07/21/25 at 10:13 A.M. of the hallway approximately ten feet from and approaching Resident #67's room revealed a strong unpleasant odor of urine. The resident was not in the room and the odor was more pungent within it. Upon walking on the floor of the room, it was sticky as the sound of adherence and the resistance as shoes pulled away from the floor was felt. The bed covers were pulled back which exposed an incontinence pad with a large, dried area of urine yellowish-brown and dried smudges of feces. The bedside table was sticky with dried spills and a large number of crumbs and debris. Interview at the time of the observation with Licensed Practical Nurse (LPN) #246 verified the observation and indicated Resident #67 had a urinary catheter but would empty the urine bag without assistance and spill it on the floor and/or bed sheets. The resident also had behaviors including refusal of housekeeping or personal care, so staff had to reapproach or clean the room after the resident left the room. Interview on 07/21/25 at 10:56 A.M. with Administrator and Director of Nursing (DON) revealed Resident #67 was considered by staff as a focus resident because of the behaviors, so the staff had to check on the resident more frequently. Review of the medical record for Resident #67 revealed an admission date of 08/23/19 with diagnoses including Alzheimer's disease, dementia, sensorineural hearing loss, urethral stricture, congestive heart failure and diabetes mellitus type two. The Annual MDS assessment dated [DATE] indicated the resident had moderate cognitive impairment and a urinary catheter. The plan of care reviewed 06/10/25 specified Resident #67 required cues and assist as needed to accomplish daily tasks and was known to empty the urinary catheter bag without assistance. Review of the facility policy, Handling Soiled Linen, revised 12/20/23, revealed soiled linen was collected at the bedside or point of use and placed into a linen bag or designated lined receptacle when task was completed. The soiled linen was not kept in a resident's room, bathroom or other care areas. Review of the facility policy, Safe and Homelike Environment, revised 01/01/22, revealed the facility provided and maintained bed and bath linens that were clean and in good condition, and minimized odors by disposing of soiled linens promptly and reporting lingering odors to housekeeping. This deficiency represents non-compliance investigated under Master Complaint Number 2570725 and Complaint Number 1342408 (OH00166879). |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365718 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Streetsboro | 1645 Maplewood Dr<br>Streetsboro, OH 44241 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365718 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arbors at Streetsboro | 1645 Maplewood Dr<br>Streetsboro, OH 44241 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review, review of Self-Reported Incident (SRI) #261204, and facility policy review, the facility failed to protect Resident #3 from verbal abuse by a staff member. This affected one (Resident #3) of four residents reviewed for abuse, neglect, misappropriation and exploitation. The facility census was 70. Findings include: Review of the medical record for Resident #3 revealed an admission date of 08/21/20 with diagnoses including Alzheimer's disease with late onset, dementia, diabetes mellitus type two, congestive heart failure, violent behavior, mood affective disorder, major depressive disorder, and nicotine dependence. Review of Resident #3's plan of care reviewed 04/25/25 revealed the resident had behaviors of increased agitation towards others, often unprovoked, verbal aggression and profanity. Review of the Annual Minimum Data Set (MDS) assessment completed 05/06/25 revealed no cognitive impairment. Review of a nursing progress note dated 05/31/25 revealed Resident #3 left outside the therapy room door. When Registered Nurse (RN) #302 asked the resident to stop, she replied shut up. Resident #3 was asked to stop letting ducks in and refused to leave the therapy room. Review of nursing progress notes dated 06/01/25 revealed RN #302 documented while on the phone with the Director of Nursing (DON) residents were in the therapy area and asked to leave but Resident #3 refused. RN #302 informed the resident she could have a police escort out if refusals continued because of safety, letting ducks into the building and administration's request to get all residents out of the therapy area. Resident #3 responded by calling RN #302 a [expletive] and stated, the nurse should make her get out. Resident #3 eventually left the therapy area. While RN #302 was at the medication cart counting narcotics in the nurses' station area, Resident #3 approached RN #302 and informed the nurse she did not want RN #302 in her room or taking care of her anymore. Resident #3 continued to state to RN #302, she don't want no [expletive] in her room, and you are a [expletive]. RN #302 told the resident it was inappropriate talk and furthermore if the resident crossed through the therapy area to the courtyard for any reason including smoking, it would be a direct infarct of the smoking rules and could result in losing smoking privileges. Resident #3 responded to RN #302 to kiss her [expletive] [expletive] and threatened to call her lawyer because RN #302 had no right to take away her smoking privileges because it was her right to do and say what she wanted, then left the nurses' station. Review of SRI tracking #261204 dated 06/04/25 revealed an allegation of verbal abuse was reported to administration via a company compliance hotline by Licensed Practical Nurse (LPN) #301 who reported she witnessed RN #302 on 05/31/25 abuse Resident #3 by calling the resident a hillbilly [expletive], and the DON witnessed it being on the phone at the time. Regional Director of Clinical Services (RDCS) #303 reviewed video evidence and found the incident occurred at approximately 7:30 P.M. to 7:40 P.M. when RN #302 and LPN #248 were seen at the medication cart near the nurses' station closest to the therapy room doors. Resident #3 approached RN #302, stated something, then walked away to the opposite end of the nurses' station nearest the therapy area by 300 hall. RN #302 then reacted by throwing both hands up in the air and pointing at Resident #3 while walking towards her, still using hand gestures continuing to point and reflecting excitability. Next, LPN #257 intervened by redirecting Resident #3 away from RN #302 out of the area toward the resident's room. As Resident #3 walked away, RN #302 continued to point at and use hand gestures but there was no audio as to what was said to the resident. RN #302 then picked up the telephone to make a call while standing at the medication cart with LPN #248. Review of the written witness statement by the DON dated 06/04/25 indicated receiving a phone call at the time of the incident from RN #302 who complained residents had exited out the therapy room doors to smoke which let ducks into the facility, and refused to listen when told to shut the door, leave the area and allow the ducks to exit the building. RN #302 reported Resident #3 was chasing after the ducks and would not listen, but eventually the residents did leave the therapy area and shut the door. RN #302 complained of both Residents #3 and #56 yelling and swearing at her about smoking and it being their right to smoke but Resident #56 did later apologize to her. RN #302 continued to complain about Resident #3 who called her a lesbian and told her they had rights to go smoke. RN #302 reported telling Resident #3 to move away from her and go to her room to defuse the situation. DON denied hearing any verbal interactions between RN #302 and Resident #3 over the telephone. Review of the written telephone interview between RDCS #303 and witness LPN #248 dated 06/04/25 indicated RN #302 was very upset, crying and talking about the workload while they were both counting narcotics at the medication cart when Resident #3 approached and |