STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365718	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Streetsboro	1645 Maplewood Dr 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of fire department and hospital records, facility policy review, and interview, the facility failed to ensure Resident #59's physician orders were followed and care planned interventions were implemented to ensure comprehensive monitoring and evaluation was provided for Resident #59, who had an implanted cardiac pacemaker to prevent complications. An additional example was the facility failed to ensure Resident #22's physician orders were followed and care planned interventions implemented to timely treat a right lateral calf wound. This affected two resident's (#22 and #59) of three residents reviewed for quality of care. The facility identified four residents with pacemakers residing in the facility. Actual Harm occurred on [DATE] at 5:30 P.M. when Resident #59 was observed to be lethargic, had clammy skin, was sweating, unable to swallow, and his oxygen saturation level was unable to be obtained. Resident #59 was placed on five liters of oxygen per minute via nasal cannula and Emergency Medical Services (EMS) was contacted. EMS completed a 12-lead electrocardiogram and noted the resident had bradycardia (indicating the heart rate was less than 60 beats per minute; when symptomatic, bradycardia can indicate a failure of the heart to pump sufficient oxygenated blood to the body). Resident #59 was urgently transported to the local hospital where he was admitted with bradycardia and concerns his implanted cardiac pacemaker battery had died and was not working appropriately. Resident #59 required inpatient care to treat his heart failure and required surgery to have a new cardiac pacemaker implanted on [DATE]. Resident #59 returned to the facility following his hospitalization. In addition, a concern that did not rise to the level of Actual Harm was identified when the facility failed to ensure a wound culture was completed for the correct wound for Resident #22. This affected one resident (#22) out of two residents reviewed for wounds. The facility census was 55.Findings include:1. Review of Resident #59's medical record revealed an admission date of [DATE] with diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure (CHF), Alzheimer's Disease, paroxysmal atrial fibrillation, dementia, cardiomyopathy, and type II diabetes mellitus with diabetic peripheral angiopathy.Review of Resident #59's Device Clinic report dated [DATE] included Resident #59's pacemaker battery had 17 months remaining, and there was normal device function. The report noted device clinic staff reprogramed the left ventricular (LV) pulse width for more battery longevity, re-demonstrated alert tones for patient and caregiver, and the next remote device check was in two to three months.Review of Resident #59's care plan dated [DATE] included Resident #59 was at risk for fluid volume imbalance related to diuretic use, CHF and other diagnoses. The care plan included Resident #59 was non-compliant with fluid restrictions and takes water on own frequently. Interventions included observing and documenting non-compliance. Review of Resident #59's care plan initiated revised [DATE] included Resident #59 had impaired cardiovascular status related to arrhythmias, atrial fibrillation, cardiomyopathy, pacemaker placement and other diagnoses. The goal developed was for Resident #59 to have reduced complications related to altered cardiac status through the next review date of [DATE]. Interventions included to administer medications as ordered, observe for side effects and report to the physician or nurse practitioner; observe for and report to the physician or nurse practitioner signs and symptoms of congestive heart failure (CHF) such as (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 0684 Level of Harm - Actual harm Residents Affected - Few	dependent edema of the legs and feet, shortness of breath upon exertion, increased weakness or fatigue, weight gain unrelated to intake, crackles and/or wheezes upon auscultation of the lungs; observe weight as ordered and as needed; provide oxygen as ordered and observe oxygen saturation levels as needed. There was no evidence of an intervention to check Resident #59's pacemaker function. Review of Resident #59's physician orders dated [DATE] included to obtain daily weights and to notify the provider of weight gain of three or more pounds in a 24-hour period or five or more pounds in a one-week period.Review of Resident #59's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had moderate cognitive impairment. Resident #59 used a wheelchair and required supervision or touching assistance for toileting and personal hygiene. Resident #59 required partial to moderate (staff) assistance with lower body dressing. Resident #59 had an indwelling catheter and was frequently incontinent of bowel.Review of Resident #59's Medication Administration Record (MAR) for [DATE] revealed no indication the resident had his daily weight monitored or recorded on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] as ordered by the physician.Review of Resident #59's progress notes dated [DATE] through [DATE] revealed there was no evidence Resident #59 refused to have his weight checked on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. There was no evidence that the physician or nurse practitioner were notified Resident #59 did not have his weight checked. There was no evidence Resident #59 was encouraged to have his weight checked daily or that there had been any additional attempts made to obtain the resident's ordered daily weights.Review of Resident #59's progress note dated [DATE] at 5:14 A.M. included Resident #59's physician was notified of a weight of 209.6 pounds and swollen legs. Resident #59's physician was notified that his last weight on [DATE] (the record indicated this weight was recorded on [DATE]) was 202.8 pounds and his weight on [DATE] was 198 pounds. The note concluded by noting the nurse was awaiting a physician response and would notify the oncoming nurse of status. Review of Resident #59's progress notes dated [DATE] at 5:14 A.M. through [DATE] at 11:47 A.M. revealed no evidence of a response received from the resident's physician for the weight gain of 6.8 pounds.However, review of Resident #59's physician orders dated [DATE] revealed a new order for the resident to receive Furosemide (an oral diuretic medication) oral tablet 40 milligrams (mg) by mouth two times a day for edema until [DATE].Review of Resident #59's progress notes dated [DATE] at 12:40 P.M. included an unnamed respiratory therapy staff notified the nurse that Resident #59's oxygen saturation level was 77 percent on room air, supplemental oxygen at two liters per minute was applied, and the resident's oxygen saturation level improved to 94 percent. Resident #59's abdomen was distended, was painful to touch, and he was very lethargic. Blood and a clot were noted in Resident #59's urinary catheter bag. The on-call nurse practitioner was contacted, and orders were received to transport Resident #59 to the ER for evaluation and treatment. Resident #59's returned to the facility the same day after the hospital addressed urinary concerns.Review of Resident #59's progress note dated [DATE] at 11:15 A.M. included Resident #59 returned to the facility via hospital transport. Resident #59 had an indwelling catheter replaced and arrived using oxygen at two liters per minute via nasal cannula. The discharge paperwork did not include findings to support oxygen therapy needed. A call was placed to the hospital ED and the nurse at the hospital was unsure why Resident #59 was placed on oxygen and he did not need it when she took care of him.Review of Resident #59's progress note dated [DATE] at 10:30 A.M. included Resident #59 needed oxygen because his oxygen saturation level was 77 percent on room air and new rhonchi (adventitious lung sounds which are caused by airway obstruction from mucus or fluid in the bronchi) were noted bilaterally. Resident #59's oxygen saturation level on oxygen at two liters per minute via nasal cannula was 93 percent.Review of Resident #59's late entry progress note dated [DATE] at 2:43 P.M. included on [DATE] at 9:30 A.M. Resident #59's right abdominal area was swollen, and he complained of right abdominal pain. The resident had returned from the hospital the night prior with an indwelling catheter. Nurse Practitioner (NP) #300 was contacted and ordered Resident #59 to be transported to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the ER for evaluation or continued urinary concerns and to have his lungs evaluated for fluid. Review of Resident #59's local fire department EMS report dated [DATE] included a call was received at 10:43 A.M. and patient contact with EMS began at 10:50 A.M. Upon EMS arrival, Resident #59 appeared slightly short of breath with notable right-sided abdominal distention that was rigid and tender to the touch. Resident #59 had bilateral lower leg edema, and blood was coming from his catheter. Resident #59 was transported to the local ED. Review of Resident #59's progress notes dated [DATE] at 2:43 P.M. included the ER was contacted and Resident #59 was being admitted to the hospital for acute and chronic CHF.Review of Resident #59's After Visit Summary dated [DATE] included Resident #59 had heart failure and had the presence of a pacemaker. Resident #59 had a referral to Cardiology for CHF management and heart failure. Resident #59's Power of Attorney (POA) reported Resident #59 had abdominal pain and a cough since Saturday ([DATE]). The abdominal pain and cough continued and Resident #59 was transported to the ED via EMS on [DATE] and received IV Lasix (diuretic) for CHF. The AVS summary included - For heart failure patients, daily weight monitoring was crucial. The AVS stated to call the doctor if you experience a weight gain of two to three pounds or more per day over a two-day period or five pounds in a week. Common heart failure symptoms included fatigue and weakness, swelling in the abdomen, legs, ankles and feet and difficulty concentrating or decreased alertness. If any of these symptoms suddenly became worse or new signs and symptoms were developed it might mean the existing heart failure was getting worse and not responding to treatment. The AVS noted Resident #59 had acute on chronic congestive heart failure and he had elevated troponin levels (a protein released into the bloodstream when heart muscle is damaged) likely due to demand ischemia. Resident #59's EKG during his hospital stay showed a complete LBBB (left bundle branch block which is an electrical conduction disorder where the left ventricle of the heart receives signals late which causes uncoordinated and inefficient contractions) with a notation that a pacemaker may be used for treatment and sinus rhythm with first degree AV block (a heart condition where electrical signals are delayed). Review of Resident #59's progress note dated [DATE] at 4:27 P.M. revealed he returned to the facility and had diagnoses including chronic CHF and pleural effusions. Resident #59 had a moist non-productive cough and was using oxygen at two to four liters per minute via nasal cannula.Review of Resident #59's progress notes, MAR and recorded weights did not reveal evidence Resident #59's weight was checked on [DATE], [DATE], or [DATE].Review of Resident #59's progress note dated [DATE] at 3:57 P.M. included at 7:45 A.M. Resident #59 was lethargic and was evaluated. Resident #59 responded appropriately with tactile stimuli, had slight tenting on the chest wall, skin was w/p/d (warm, pale, and dry), lungs had slight rhonchi in the lower lobes with a productive cough. The nurse practitioner (unidentified) gave orders. Resident #59's temperature was 97.0 degrees Fahrenheit, his pulse was 52 (bradycardia), respirations 18, and blood pressure was 121/59. At 11:30 A.M., Resident #59 was sitting in his wheelchair, ate his lunch, and was taken to participate in activities.Review of Resident #59's medical record dated [DATE] through [DATE] revealed no evidence facility staff arranged for additional visits to the device clinic for the resident or that any remote checks were completed in the facility for the resident's pacemaker during this time period.Review of Resident #59's progress note dated [DATE] at 12:43 P.M. revealed a referral was faxed to the hospital scheduling department for a cardiology consultation. Review of Resident #59's local fire department EMS report dated [DATE] included a call was received at 5:14 P.M. and patient contact began at 5:19 P.M. Resident #59 was found sitting in a wheelchair, was on an oxygen concentrator, and was diaphoretic. Resident #59 was hypoglycemic and bradycardic and was transported to the ED.Review of Resident #59's progress note dated [DATE] at 6:17 P.M. included Resident #59's blood sugar at 4:00 P.M. was 370 and he was administered insulin per sliding scale. At 5:30 P.M., Resident #59 opened his eyes to tactile stimuli then went back to sleep. His skin was clammy, he was sweating, and he was unable to swallow. Sugar was administered via his drink with minimal responsiveness. Resident #59's temperature was 97.6 degrees Fahrenheit, pulse 52, respirations 20, and blood pressure was 102/62. Resident #59's (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	oxygen saturation level was unable to be obtained, and he was placed on five liters of oxygen per minute via nasal cannula. 911 was called and Resident #59 was transported to the hospital. Review of Resident #59's After Visit Summary dated [DATE] through [DATE] included Resident #59's admission diagnosis was bradycardia. Resident #59 had sinus bradycardia at 44 beats per minute and a LBBB. Resident #59's pacemaker was attempted to be interrogated, but there were concerns the battery had died. The case was discussed with cardiology, and he would be admitted for further care. Resident #59's POA was notified of concerns about his pacemaker not working appropriately and she was agreeable with bloodwork and an interrogation. Resident #59 had bradycardia and pacemaker malfunction. Resident #59's pacemaker report indicated the battery may have run out sometime in 2025. Resident #59 required surgery to implant a new cardiac pacemaker which was completed on [DATE]. Resident #59 was discharged from the hospital back to the facility on [DATE] with a referral to hospice services and an appointment for a cardiac device check scheduled at the device clinic on [DATE] at 8:00 A.M. Review of Resident #59's progress note dated [DATE] at 6:06 P.M. included Resident #59 returned to the facility at about 4:45 P.M. Resident #59 was very lethargic but responded to staff. A small area was noted on Resident #59's left upper chest from the pacemaker replacement at the hospital. Resident #59 was lying in bed resting quietly with his eyes closed.On [DATE] at 9:44 A.M. Resident #59 was observed sitting in his wheelchair and asked for help to use the bathroom. Resident #59 asked for blinds to his windows be opened so he could see outside. Resident #59 was pleasant and answered questions appropriately.On [DATE] at 9:44 A.M. interview with Licensed Practical Nurse (LPN) #238 revealed Resident #59 was back to himself now and was eating and acting like he used to act. LPN #238 stated Resident #59's pacemaker battery died, and he needed to have it (pacemaker) replaced about two weeks ago and he was much better now. LPN #238 stated Resident #59's decline was absolutely related to his pacemaker not working. LPN #238 indicated Resident #59 was put on hospice because staff thought he was dying. Interview on [DATE] at 11:05 A.M. with Resident #59's POA, POA #600 revealed Resident #59's catheter was put in wrong and he had to go to the hospital on [DATE]. POA #600 stated Resident #59 had to be transported to the hospital on [DATE] because he was filling up with fluid from his CHF. POA #600 indicated Resident #59 was out of it, restless, delusional, and in bad shape when he was at the hospital and the physician recommended hospice services. POA #600 stated Resident #59 was in the hospital when they found out his pacemaker was not working and put a new one in. He came back to the facility from the hospital on [DATE]. POA #600 stated after Resident #59's pacemaker battery was replaced, he was improving.Interview on [DATE] at 4:12 P.M. with Certified Nursing Assistant (CNA) #263 revealed Resident #59 was taken to the hospital about two weeks ago but he did not know why he was taken to the hospital. When Resident #59 returned to the facility from the hospital, we thought he was going to die, and he was put on hospice services. CNA #263 indicated Resident #59 had suddenly begun feeling better, talking more clearly, pressing his call light, and now he was eating and allowing staff to provide his care. CNA #263 stated before Resident #59 went to the hospital he was shaky but now he was better and not shaking.Interview on [DATE] at 4:51 P.M. with Hospice Nurse (HN) #601 revealed Resident #59 was admitted to hospice services on [DATE] because he had signs and symptoms of end of life. Resident #59 was unresponsive and the even more care (EMC) program was initiated because he appeared to be actively passing. HN #601 revealed Resident #59 bounced back starting on [DATE] when Resident #59 began talking, drinking fluids and then he started going to activities and was back to his baseline. Interview on [DATE] at 8:47 A.M. with the Director of Nursing (DON) revealed she was not sure whether Resident #59's pacemaker's battery died and she would investigate it. The DON stated all residents with pacemakers should have pacemaker checks in place. A follow up interview on [DATE] at 11:18 A.M. with the DON revealed after looking into Resident #59's record, she found out his pacemaker was last checked on [DATE]. The DON stated Resident #59 had a device in his room to check his pacemaker remotely, but the device was not working. The DON stated there should have been remote checks done on Resident #59's pacemaker.Observation on (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of a fire department transportation reports, review of hospital After Visit Summaries, and interview, the facility failed to ensure residents were provided adequate monitoring and/or care per physician order to timely identify and seek interventions for complications of the residents urinary status including symptoms of a urinary tract infection. This affected two residents (#59 and #70) of three reviewed for urinary tract infections. The facility census was 55.Actual Harm occurred on 01/20/26 when Resident #70 began showing signs and symptoms of a urinary tract infection (UTI). However, the resident was not appropriately evaluated or monitored after showing these symptoms and began showing a change in condition on 01/22/26 when his right arm began to shake. The resident was subsequently transferred to the hospital on [DATE] and was diagnosed with acute cystitis, urinary tract infection (UTI), sepsis with acute organ dysfunction (multi), acute hypoxic respiratory failure and acute decompensated heart failure.Actual Harm occurred beginning on 01/24/26 at 2:06 P.M. when Resident #59 notified the nurse his catheter was pulled out the night before; a new catheter was inserted and after the new catheter was inserted, blood was observed. However, there was no evidence Resident #59 was monitored for blood in his urine until 01/25/26 at 11:47 A.M. when the resident had minimal urine output recorded and was found lethargic, his abdomen was distended and painful to touch, and there was blood and blood clots observed in his urinary catheter bag. Resident #59 was transported to the emergency department (ED) where his urinary catheter was identified to be misplaced. The catheter was removed and a new catheter was inserted. Findings include: 1. Review of Resident #59's medical record revealed an admission date of 08/23/19 with diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure, Alzheimer's Disease, obstructive and reflux uropathy, malignant neoplasm of the prostate, type two diabetes mellitus with diabetic peripheral angiopathy without gangrene, dementia, and cardiomyopathy.Review of Resident #59's care plan dated 11/15/24, revised on 11/12/25, included Resident #59 had a need for an indwelling catheter, size 18 French (F) with a 10 cubic centimeter (cc) balloon related to prostate cancer and obstructive uropathy. The care plan included Resident #59 refused a leg bag and refused to allow his catheter to be placed appropriately through his pant leg. The goal developed was for Resident #59 to have reduced catheter-related complications through the next review. Interventions included to observe for signs and symptoms of urinary tract infection (UTI) and report blood in urine, cloudiness, foul smell, fever, or change in mental status to the physician, assist Resident #59 with indwelling catheter care as needed, and change catheter and drainage system as clinically indicated per orders.Review of Resident #59's care plan dated 11/15/24 included Resident #59 was at risk for a fluid volume imbalance related to his diagnoses. The care plan included Resident #59 was noncompliant with fluid restrictions and obtained water on his own frequently. The goal developed was for Resident #59 to have reduced signs and symptoms of fluid deficit including decreased urine output. Interventions included to observe and report to the physician or nurse practitioner, as needed, signs and symptoms of dehydration including decreased or no urine output and concentrated urine.Review of Resident #59's physician orders dated 11/12/25 included orders to change the indwelling catheter, 18 French with a 10 cc balloon, related to obstructive uropathy as clinically indicated for signs and symptoms of obstruction such as leakage, increased sediment, infection, or if the closed system was compromised.Review of Resident #59's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had moderate cognitive impairment. Resident #59 used a wheelchair and required supervision or touching assistance for toileting and personal hygiene and required partial to moderate assistance with lower body dressing. The assessment noted Resident #59 had an indwelling catheter and was frequently incontinent of bowel.Review of Resident #59's physician orders revealed orders dated 01/16/26 for Lidocaine Pain (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Relief patch 4 percent (%), with instructions to apply to lower back topically one time a day for back pain and apply on the morning and take off at bedtime, and Acetaminophen 325 milligrams (mg) with instructions to give two tablets by mouth every six hours as needed for mild pain. Further review of the physician orders dated 01/16/26 through 01/19/26 revealed no documented evidence of an order for a urine specimen for urinalysis and culture and sensitivity during this time. Review of Resident #59's progress notes dated 01/19/26 at 4:18 P.M. revealed Resident #59 had increased pain to an unidentified area, not relieved by Tylenol (Acetaminophen), a Lidocaine patch, or repositioning. The progress note included Resident #59 had new orders for as needed Ibuprofen and a urine specimen for urinalysis and culture and sensitivity.Review of Resident #59's progress notes dated 01/19/26 at 4:18 P.M. through 01/22/26 at 1:30 A.M. revealed no documented evidence of attempts made to collect Resident #59's urine for urinalysis and culture and sensitivity.Review of Resident #59's progress notes dated 01/20/26 at 10:30 A.M. included a Lidocaine Pain Relief patch 4% was applied to Resident #59's lower back for complaints of back pain. Resident #59 stated this did not help and a message was sent to the provider. Review of Resident #59's progress notes dated 01/21/26 at 10:20 P.M. revealed Resident #59 was administered two tablets of Acetaminophen 325 (mg) for pain in the lower back rated from a one to three out of ten (on a pain scale where zero was no pain and 10 being the worst pain). The medication was documented as effective.Review of Resident #59's aide charting indicated aides were to monitor fluid output every twelve hours. Review of the urine output documentation dated 01/21/26 at 3:33 P.M. revealed only 20 cubic centimeters (cc) of urine output was recorded. There was no urine output recorded on 01/22/26 at 7:06 A.M. as staff noted the resident had refused. Review of Resident #59's progress notes dated 01/21/26 at 3:33 P.M. through 01/23/26 at 5:54 A.M. revealed no documented evidence Resident #59 had urine output recorded.Review of Resident #59's physician orders dated 01/21/26 at 4:15 P.M. revealed an order to obtain urine for urinalysis and culture and sensitivity.Review of Resident #59's progress note dated 01/22/26 at 1:30 A.M. included Resident #59's urine specimen was unable to be sent to the lab because the lab representative left before Resident #59's urine specimen was collected. The catheter was clamped off and waiting for urine to accumulate but the lab collector left before there was enough urine to collect. There was no documented evidence in the progress note indicating how long the catheter was clamped and waiting for urine to accumulate. Review of Resident #59's progress notes dated 01/22/26 at 4:21 A.M. included two tablets of Acetaminophen 325 mg were administered to Resident #59 for complaints of pain rated a one to three out of 10, for pain in the lower back. Resident #59 rated his follow up pain at a two out of 10.Review of Resident #59's progress notes dated 01/22/26 at 6:54 A.M. included an unidentified physician representative spoke with Resident #59 and told the nurse she thought Resident #59 stated his pain was fine and controlled. The physician representative was informed Resident #59 was up all night complaining of pain and his medications were not effective. Gabapentin 100 mg by mouth was prescribed daily at bedtime for back pain.Review of Resident #59's Treatment Administration Record (TAR) revealed a urine specimen for urinalysis (UA) and culture and sensitivity (C and S) was collected on 01/22/26 at 2:22 P.M.Review of Resident #59's progress note dated 01/22/26 at 2:23 P.M. documented Resident #59's indwelling catheter and catheter bag were changed with no issues. Pale, yellow urine drained immediately and a urine sample was collected for UA C and S to be sent out on 01/23/26. A stat lock (a medical stabilization device used to secure an indwelling catheter to a patient's skin using an adhesive pad and a locking plastic clip) was placed on Resident #59's left leg to hold the indwelling catheter in place. Resident #59 denied pain or discomfort at this time. There was no documentation indicating why Resident #59's catheter needed to be changed at this time.Review of Resident #59's progress notes dated 01/22/26 at 2:34 P.M. revealed Ibuprofen 200 mg was administered for complaints of back pain rated a five out of a 10. All non-pharmacological interventions were ineffective. Resident #59's follow up pain scale was 0 indicating the Ibuprofen was effective.Review of Resident #59's progress notes dated 01/23/26 at 2:43 A.M. revealed Resident #59 was (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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F 0690 Level of Harm - Actual harm Residents Affected - Few	administered two Acetaminophen 325 mg tablets for complaints of pain in the lower back. Resident #59 rated his pain as one to three on a zero to 10 pain scale. Resident #59's follow up pain check revealed the Acetaminophen was effective.Review of Resident #59's progress notes dated 01/23/26 at 4:50 A.M. included Resident #59 was administered an Ibuprofen 200 mg tablet for pain in the lower back. Resident #59's pain level was not documented. Resident #59's follow up pain check revealed the Ibuprofen was effective.Review of Resident #59's progress notes dated 01/23/26 at 1:25 P.M. revealed Resident #59 was administered two Acetaminophen 325 mg tablets for complaints of pain of one to three out of 10. Resident #59's follow up pain check revealed his pain was rated at a two.Review of Resident #59's progress notes dated 01/24/26 at 6:45 A.M. revealed Resident #59 was administered Ibuprofen 200 mg and his follow up pain check was rated a five out of a 10.Review of Resident #59's TAR revealed on 01/24/26 at 2:04 P.M. Resident #59's indwelling catheter was changed.Review of Resident #59's progress notes dated 01/24/26 at 2:06 P.M. revealed on 01/24/26 at 12:00 P.M. Resident #59 notified the nurse that his indwelling catheter was pulled out the night before. A new order was received insert a 16 French catheter with a 15 cc balloon inside of Resident #59. The catheter was placed and Resident #59's catheter had red blood in it due to the pulling of the previous catheter. Resident #59 complained of a burning sensation that went away after a while. Pain medication was given. It noted that staff would continue to monitor. There was no evidence in Resident #59's medical record including progress notes dated 01/23/26 at 1:25 P.M. through 01/24/26 at 2:06 P.M. the resident's indwelling catheter was pulled out the night before or why the catheter was changed.Review of Resident #59's progress notes dated 01/24/26 at 2:06 P.M. through 01/25/26 at 11:47 A.M. revealed no documented evidence that Resident #59 was evaluated and monitored for blood in his urine. There was no evidence Resident #59's physician was notified of the blood in his urine.Review of Resident #59's aide charting for urine output revealed from 01/24/26 at 4:32 P.M. through 01/25/26 at 4:39 A.M. there was no urine output recorded. On 01/25/26 at 4:39 A.M., 300 cc of urine was recorded. There was no additional urine recorded from 01/25/26 at 4:39 A.M. through 01/25/26 at 12:40 P.M. when Resident #59 was transported to the local emergency room (ER).Review of Resident #59's local fire department [NAME] Review Transportation Report dated 01/25/26 included a call was received at 10:39 A.M. and emergency medical services (EMS) had patient contact at 10:49 A.M. Resident #59 complained of bad pain and the staff at the facility stated Resident #59 was having issues with his urinary catheter. Resident #59's indwelling catheter had fallen out several times recently and staff denied Resident #59 pulled his catheter out. Staff stated they attempted to put more air in the balloon to keep it secure. Staff stated Resident #59 had straight blood in his indwelling catheter last night. Staff believed he had some urine output since placement, but there was no urine currently in the bag. Resident #59's abdomen was distended in the right quadrants, not firm, and his abdomen was tender in all quadrants.Review of Resident #59's progress note dated 01/25/26 at 11:47 A.M. revealed Respiratory Therapist #272 walked into Resident #59's room and noticed blood and blood clots in Resident #59's urine catheter bag. Resident #59 was very lethargic, and his abdomen was extended and painful to touch. Resident #59's oxygen saturation level was 77 percent (%) (normal ranges from around 95% to 100%) on room air and oxygen at two liter per minute was applied. Resident #59's oxygen saturation level was 94 percent on oxygen two liters per minute, pulse 76 beats per minute (bpm) (normal ranges from 60 to 100 bpm), respirations 20 breaths per minute (normal ranges from 12 to 20 breaths per minute), and temperature was 100.3 Fahrenheit (F) (normal ranges from around 97 degrees F to 99 degrees F). Resident #59 was transported to the hospital.Review of Resident #59's progress note dated 01/25/26 at 12:40 P.M. included Respiratory Therapist #272 notified the nurse Resident #59's oxygen saturation level was 77% on room air, oxygen two liters per minute was applied and his oxygen saturation level improved to 94%. Resident #59's abdomen was distended, was painful to touch and he was very lethargic. Blood and a clot were noted in Resident #59's urinary catheter bag. The resident's unidentified on-call Nurse Practitioner was contacted and orders were given to transport Resident #59 to the ER for evaluation and (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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F 0690 Level of Harm - Actual harm Residents Affected - Few	treatment.Review of Resident #59's hospital notes dated 01/25/26 revealed Resident #59 was diagnosed with a urinary tract infection associated with his indwelling urethral catheter, a problem with his indwelling catheter and a urethral injury. The facility was experiencing clogging of Resident #59's catheter, the facility took Resident #59's catheter out put a new one in and now the new catheter was draining minimal urine. Resident #59's catheter was removed, and a new urethral catheter was inserted in the ED. The notes included Resident #59 had a urine specimen collected for urinalysis and reflex culture. Resident #59's urine specimen for urinalysis was abnormal. Resident #59's white blood cell (WBC) counts were greater than 50 cells per HPF (high-power field) (normal was 1 to 5 cells), and a finding greater than 50 WBC's indicated high levels of inflammation or infection within the urinary tract. Resident #59's red blood cell (RBC) counts were greater than 20 cells per HPF (normal was 0 to 3 per HPF, and greater than 3 to 5 per HPF was flagged as high and often indicated a urinary tract infection). Resident #59's urine was dark-brown, turbid, and had over three plus blood (indicating a significant amount of blood) in the urine. Resident #59 had a computed tomography (CT) scan of the abdomen and pelvis and there was a suspected type two posterior urethral injury (severe iatrogenic urethral trauma, can be caused by a malplaced or improperly handled catheter) with fluid-filled peripheral enhancing outpouching along the course of the prostatic urethra, newly seen since 11/14/24. It noted that enhancement along the margin of the collection may be due to the healing response, inflammation, or infection. A urologic consultation was completed, and the urologist found Resident #59 did not require emergent urological intervention and could follow up as an outpatient. Discharge instructions included to schedule an appointment as soon as possible for a visit in one week, and noted Resident #59 was discharged with antibiotics for a UTI and to follow up with the ED if symptoms worsen. Review of Resident #59's progress note dated 01/25/26 11:15 P.M. included Resident #59 returned to the facility via hospital transport. Resident #59 had his indwelling catheter replaced and it was draining appropriately. Hematuria (blood in the urine) was noted related to the urethral injury.Review of Resident #59's aide charting revealed no documented evidence urine output was documented from 01/25/26 at 11:15 P.M. through 01/26/25 at 10:50 A.M. when EMS arrived to transport Resident #59 back to the ED.Review of Resident #59's progress notes dated 01/25/26 at 11:15 P.M. through 01/26/25 at 9:30 A.M. revealed no documented evidence Resident #59 was monitored and evaluated for a change of condition including blood and urine in his indwelling catheter.Review of Resident #59's late entry progress notes dated 01/26/26 at 2:43 P.M. included on 01/26/26 at 9:30 A.M., Resident #59's right abdominal area was swollen and he complained of right abdominal pain. The note referenced how Resident #59 returned from the hospital last night [indicating 01/25/26] with an indwelling catheter and a CT scan stated the catheter was not in the correct place and Resident #59 needed to follow up with the urology service to have his indwelling catheter placed in the correct position. Nurse Practitioner (NP) #300 was contacted [regarding the new abdominal swelling and complaints of right abdominal pain] and ordered Resident #59 to be transported to the ED to have correct placement of his indwelling catheter and to have his lungs evaluated for fluid. Review of Resident #59's local fire department [NAME] Review Transportation Report dated 01/26/26 included a call was received from the facility at 10:43 A.M and patient contact was at 10:50 A.M. The report noted that Resident #59 had catheter issues and the facility advised that Resident #59 was sent back from the hospital with the catheter in wrong, and Resident #59 had abdominal distention that was not normal. Resident #59 appeared slightly short of breath with notable right-sided abdominal distention that was rigged and tender to touch. There was blood coming from his catheter. Resident #59 was transported to the ED.Review of Resident #59's hospital notes dated 01/27/26 through 01/30/26 included Resident #59 had a history of urinary retention with an indwelling catheter and urethral stricture. Resident #59's Power of Attorney (POA) stated Resident #59 was not feeling well and reported abdominal pain and a cough since 01/24/26. Resident #59 had an indwelling catheter placed at the facility, it was malplaced and hematuria was noted on 01/25/26. Resident #59 was transported to the ED on 01/25/26 and was found to have a UTI, a new indwelling (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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F 0690 Level of Harm - Actual harm Residents Affected - Few	catheter was placed, and he was given a prescription for Augmentin (an antibiotic medication). Resident #59's abdominal pain and cough continued when he returned to the facility [on 01/25/26] and on 01/26/26 he was transferred from the facility to the ED via EMS. Resident #59 was transported to the hospital, and he was positive for dysuria, hematuria, penile pain, and had bleeding around the tip of the urethra. The note also included back tenderness was present. Resident #59 was admitted to the hospital and diagnoses included UTI. Resident #59 was ordered intravenous (IV) Ertapenem (an antibiotic medication) 1 gram (g) per 50 milliliters (ml), for one week from 01/28/26 through 02/03/26 via a midline catheter, for a UTI. Resident #59 needed to follow up with urology for outpatient management of his urethral injury.An observation on 02/19/26 at 9:44 A.M. of Resident #59 revealed he was sitting in his wheelchair and asked for help to use the bathroom. An interview on 02/19/26 at 11:05 A.M. with Power of Attorney (POA) #600 revealed she was Resident #59's POA. POA #600 stated the facility put Resident #59's catheter in wrong and on 01/25/26 he was transported to the ED. POA #600 indicated Resident #59 returned to the facility and had to be transported a second time to the ED due to issues with his catheter. POA #600 stated it was very upsetting that the facility put his catheter in wrong and he had to go to the ED because of it.An interview on 02/23/26 at 8:58 A.M. with Respiratory Therapist (RT) #272 revealed on 01/25/26 she walked by Resident #59's room and noticed the resident was still in bed and that was unusual for him because he usually got himself up. RT #272 indicated she entered Resident #59's room to check on him and noticed blood and clots in his urinary catheter bag. RT #272 stated she tried to wake Resident #59 up, but he was very lethargic and his abdomen was swollen. RT #272 called Licensed Practical Nurse (LPN) #238 to his room, and LPN #238 checked Resident #59's vital signs, he had a fever of 100.3 degrees F and his oxygen saturation level was 77%. Resident #59 was transported to the ED via EMS.An interview on 02/23/26 at 12:05 P.M. with LPN #208 revealed on 01/26/26 Resident #59 was having pain in his abdomen, there was a bulge and the right side was swollen. Resident #59 was holding his abdomen, was in pain, was confused and he did not say how bad his pain was. LPN #208 stated Resident #59 said ow when she touched his abdomen. LPN #208 stated Resident #59 never had a bump in his abdomen before and she read Resident #59's hospital notes from 01/25/26, the CT scan showed the catheter was not in the correct place, and the ED physician took out the catheter that was in the wrong place and put a new catheter in. LPN #208 stated no one told her this information, but she read it when she reviewed the hospital notes. LPN #208 contacted Nurse Practitioner #300 on 01/26/26 and Resident #59 was sent to the ED via 911. Resident #59 was sent back to the facility on [DATE] and was supposed to have a follow-up appointment with a urologist. LPN #208 revealed the nurse had a difficult time putting Resident #59's catheter in on 01/24/26, there was no urine coming out, and Resident #59 was transported to the ED on 01/25/26.An interview on 02/23/26 at 5:15 P.M. with Regional Director of Clinical Services (RDCS) #301 confirmed the above findings and she stated she did not find additional information to add. Review of the facility policy titled Catheter Care Procedure-Urinary revised 12/28/23 included it was the policy of the facility to provide catheter care to all residents that had an indwelling catheter in an effort to reduce bladder and kidney infections, while maintaining their dignity and privacy. Residents with an indwelling catheter would be provided catheter care in accordance with current clinical standards. This might include every shift and as needed and per request. Catheters should be emptied every shift or as needed and urinary output should be recorded per facility protocol. 2. Review of Resident #70's closed medical record revealed an admission date of 09/04/25 and a discharge date of 01/24/26. Resident #70's diagnoses included chronic systolic (congestive) heart failure (CHF), type two diabetes mellitus with diabetic chronic kidney disease and diabetic retinopathy with macular edema and acquired absence of the right leg above the knee. Review of Resident #70's care plan dated 09/05/25 included Resident #70 was at risk for fluid volume deficit (the care plan did not specify what the fluid volume deficit was related to). It noted Resident #70 would maintain moist mucous membranes and good skin turgor through the next review. Interventions included to encourage Resident #70 to drink fluids of choice unless (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	amputation on the right side, type two diabetes mellitus complicated by neuropathy. Resident #70 had congestive heart failure (CHF), coronary artery disease and was status post coronary artery bypass grafting (CABG) and implantable cardioverter-defibrillator (ICD). Resident #70 presented from the facility with concern for shaking of his hands throughout the day yesterday (01/23/26). At that time Resident #70 denied acute concerns. Work up in the ED revealed the resident was positive for a UTI and Resident #70 was found to have elevated troponin [indicating potential heart muscle damage] and was hypoxic (low levels of oxygen). Resident #70 refused supplemental oxygen even after being informed of negative consequences including death. Resident #70 was diaphoretic and started projectile vomiting. Resident #70 endorsed having an episode of emesis at the facility yesterday. Resident #70's assessment included acute cystitis, sepsis with acute organ dysfunction (multi) for which blood and wound cultures were obtained and antibiotics administered, acute hypoxic respiratory failure and acute decompensated heart failure.Further review of Resident #70's medical records revealed no additional documentation was available for review.An interview on 02/19/26 at 5:15 P.M. with Licensed Practical Nurse (LPN) #238 revealed she sent Resident #70 to the hospital on [DATE]. LPN #238 stated she was taking care of Resident #70 when he complained of burning on urination and rated his pain a six out of a 10. LPN #238 stated she called an unidentified nurse practitioner about the resident's pain and burning on urination. LPN #238 stated she thought Resident #70 did not want to have a urine specimen collected for urinalysis and culture and sensitivity because he said he was feeling fine. LPN #238 revealed she was almost positive she was given an order for a urine culture and Resident #70 said no he did not want one; however, she confirmed she did not document she was given an order or that Resident #70 refused to have a urine specimen collected. LPN #238 stated as far as she knew no urine specimen was sent to the lab for analysis. LPN #238 stated Resident #70 sometimes refused to have care completed and then stated Resident #70 had passed away at the hospital around 02/02/26.An interview on 02/23/26 at 5:15 P.M. with Regional Director of Clinical Services #301 revealed she could find no additional information and confirmed there was no evidence Resident #70 was monitored or evaluated for pain and burning upon urination, no evidence a urine specimen was ordered or collected and sent to the lab for a urinalysis or C&S and no evidence Resident #70 was monitored for shaking of his right arm or that the physician was aware of it.Review of the facility policy titled Notification of Changes revised 08/29/24 included the purpose of the policy was to ensure the facility promptly informed the resident, consulted the resident's physician, and notified, consistent with his or her authority the resident's representative when there was a change requiring notification. This deficiency represents non-compliance investigated under Complaint Number 2647655.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365718	A. Building B. Wing	03/03/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review, interview and review of facility policy, the facility did not ensure a designated Infection Preventionist provided oversight, monitoring and management of all components of the Infection Prevention and Control Program. This had the potential to affect all 55 residents in the facility. Findings Include: Review of immunization records for Resident #5, #16, #24, #40 and #61 revealed concerns with an unidentified staff member completing vaccination education and consent forms with the residents and/or responsible parties as followed: Review of Resident #5's immunization consent forms for Covid-19, influenza and pneumococcal vaccine's revealed education and all three consents were provided to the resident's daughter on 02/05/26 and the staff member obtaining verbal consent was not identified on the forms. There was no witness signature on the forms. Review of Resident #16's immunization consent forms for Covid-19, influenza and pneumococcal vaccine's revealed education and all three consents were provided to the resident's responsible party on 09/19/25 and the staff member obtaining verbal consent was not identified on the forms. There was no witness signature on the forms. Review of Resident #24's immunization consent forms for Covid-19, influenza and pneumococcal vaccine's revealed education and all three consents were provided to the resident's responsible party on 09/17/25 and the staff member obtaining verbal consent was not identified on the forms. There was no witness signature on the forms. Review of Resident #40's immunization consent forms for Covid-19, influenza and pneumococcal vaccine's revealed education and all three consents were provided to the resident's responsible party on 09/16/25 and the staff member obtaining verbal consent was not identified on the forms. There was no witness signature on the forms. Review of Resident #61's immunization consent forms for Covid-19, influenza and pneumococcal vaccines revealed the resident was their own responsible party and gave verbal consent for vaccinations on 09/15/25. The staff member providing education and obtaining verbal consent was not identified on the forms. There was no witness signature on the forms. In addition, Review of the facility's Infection Surveillance Report dated November 2025, December 2025, and January 2026 revealed in the month of November 2025 there were 28 identified infections requiring antibiotic use. Eighteen of the infections were checked did not meet McGeer's criteria for antibiotic use. In December 2025 there were 22 identified infections. Eighteen of the infections were checked did not meet McGeer's criteria for antibiotic use. In January 2026 there were 18 identified infections. Thirteen of the infections were checked did not meet McGreer's criteria for antibiotic use. The report did not indicate if any follow-upevaluation had been completed regarding the infections not meeting the standards for antibiotic use. Review of the facility's Annual Long Term Care Facility Self-Assessment Tool, dated 09/03/25, revealed Regional Director of Clinical Services (RDCS) #301 was listed as the Infection Preventionist for the facility. An interview was conducted on 02/19/26 at 4:10 P.M. with the Administrator who revealed RDCS #301 was the Infection Preventionist for the facility, but the Administrator was unsure if she was in the facility at least part-time. The Administrator stated she believed Licensed Practical Nurse (LPN) #235 who worked full-time in the facility was also an Infection Preventionist as well as the Minimum Data Set (MDS) nurse for the facility. The Administrator provided a certificate for LPN #235 to verify LPN #235 had been certified as an Infection Preventionist. An interview on 02/25/26 at 4:05 P.M. with RDCS #301 confirmed the facility did not have at least a part-time Infection Preventionist in place to ensure the infection prevention and control program was being consistently implemented and monitored in the facility. RCDS #301 stated LPN #235 worked full-time as the MDS nurse and helped with the infection control log, but did not oversee the infection prevention and control program in the facility. RDCS #301 statedthe facility usually had the Staff Development Coordinator (SDC) assume the role of the Infection Preventionist or had several people in the role of the Infection Preventionist but they had not lasted with the facility. RDCS #301 stated the facility just hired a new Infection (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Preventionist who started the previous week, and the facility had three other nurses besides herself working as the Infection Preventionist in the past year. RDCS #301 confirmed the immunization consents for Resident #61, #40, #24, #16 and #5 were not completed by an identifiable staff person and confirmed the infection surveillance report identified 49 infections that did not meet McGreer's criteria for antibiotic use with no evidence of follow-up on the report. Review of the facility's Infection Prevention and Control Program, last revised 12/27/23, revealed the Infection Preventionist (IP) is responsible for oversight of the Infection Control program and serves a consultant for staff on infectious disease, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigation of exposures of infectious diseases. The IP serves as leader of the antibiotic stewardship program. The IP is responsible for oversight of the Covid-19, influenza and pneumococcal vaccinations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident's #17, #33, #59, #66, #67 and #70's physician orders were followed for medication administration. This affected six residents (Resident's #17, #33, #59, #66, #67 and #70) out of six reviewed for medication administration and had the potential to affect all twelve residents residing on the 400 nursing unit. The facility census was 55.Findings include: 1. Review of Resident #70's medical record revealed an admission date of 09/04/25 and a discharge date of 01/24/26. Resident #70's diagnoses included chronic systolic (congestive) heart failure (CHF), type two diabetes mellitus with diabetic chronic kidney disease and diabetic retinopathy with macular edema, and acquired absence of the right leg above the knee. Review of Resident #70's physician orders dated 09/04/25 revealed insulin lispro subcutaneous solution pen-injector 100 units per milliliter (ml) with instructions to inject per sliding scale, if Resident #70's blood sugar was 150 to 199 administer three units insulin, if it was 200 to 249 administer six units, if it was 250 to 299 administer nine units, if it was 300 to 349 administer 12 units, if it was 350 to 400 administer 15 units and above 400 give 18 units and call the physician, subcutaneously before meals and at bedtime for type two diabetes mellitus. Review of Resident #70's Medication Administration Record (MAR) dated 10/30/25 revealed there was no evidence insulin lispro subcutaneous solution pen-injector 100 units per ml was administered per sliding scale at 11:00 A.M before the lunch meal or at 4:00 P.M. before the dinner meal. There was no evidence Resident #70's blood sugars were checked at 11:00 A.M. and 4:00 P.M. as ordered. Review of Resident #70's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #70 was cognitively intact. Resident #70 had impairment on both sides of the lower extremities and used a wheelchair. Resident #70 was dependent on staff for toileting hygiene and required substantial to maximum assistance with bathing and lower body dressing. It noted that Resident #70 was always incontinent of urine and bowel. 2. Review of Resident #59's medical record revealed an admission date of 08/23/19 and diagnoses included chronic combined systolic (congestive) and diastolic (congestive) heart failure, Alzheimer's Disease, paroxysmal atrial fibrillation, type two diabetes mellitus with diabetic peripheral angiopathy without gangrene, dementia, and cardiomyopathy. Review of Resident #59's physician orders dated 11/15/24 revealed Novolog flex-pen subcutaneous solution pen-injector 100 units per ml subcutaneously before meals and at bedtime for diabetes mellitus, with instructions to inject per sliding scale. If Resident #59's blood sugar was 180 to 240 inject two units, if it was 241 to 300 administer four units, if it was 301 to 360 administer six units, if it was 361 to 400 administer eight units and above 400 call the physician. Review of Resident #59's MAR dated 10/30/25 revealed no evidence at 11:00 A.M. that Resident #59's blood sugar was checked and insulin was administered per sliding scale as ordered. Review of Resident #59's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had moderate cognitive impairment. Resident #59 used a wheelchair and required (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supervision or touching assistance for toileting and personal hygiene. Resident #59 required partial to moderate assistance with lower body dressing. Resident #59 had an indwelling catheter and was frequently incontinent of bowel. 3. Review of Resident #66's medical record revealed an admission date of 08/21/20 and a discharge date of 11/03/25. Resident #66's diagnoses included Alzheimer's Disease, dementia, type two diabetes mellitus and chronic diastolic (congestive) heart failure. Review of Resident #66's physician orders dated 08/13/25 revealed insulin glargine-yfgn 100 units per ml pen with instructions to inject 16 units subcutaneously one time a day related to type two diabetes mellitus with hyperglycemia. Review of Resident #66's MAR dated 10/30/25 revealed there was no evidence insulin glargine-yfgn was administered at 9:00 A.M. as ordered. 4. Review of Resident #67's medical record revealed an admission date of 07/18/25 and a discharge date of 01/13/26. Resident #67's diagnoses included unspecified convulsions, multiple fractures of the pelvis with stable disruption of the pelvic ring, initial encounter for closed fracture, and obesity. Review of Resident #67's physician orders dated 07/20/25 revealed orders for a Phenobarbital oral tablet 32.4 mg with instructions to give one tablet orally every eight hours for seizures. Review of Resident #67's MAR dated 10/30/25 did not reveal evidence Resident #67 was administered Phenobarbital 32.4 mg at 2:00 P.M. as ordered. Review of Resident #67's Controlled Drug Record dated 10/30/25 at 2:00 P.M. did not reveal evidence Resident #67's Phenobarbital 32.4 mg was signed off it was administered. 5. Review of Resident #17's medical record revealed an admission date of 10/03/23 and diagnoses included rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites, [NAME]-Danlos syndrome, and major depressive disorder. Review of Resident #17's physician orders dated 03/12/25 revealed orders for Oxycodone oral capsule 5 mg with instructions to give one by mouth three times a day for pain. Review of Resident #17's MAR dated 10/30/25 at 2:00 P.M. revealed there was no evidence Oxycodone 5 mg was administered as ordered. Review of Resident #17's Controlled Drug Record dated 10/30/25 at 2:00 P.M. did not reveal evidence Resident #17's Oxycodone 5 mg was signed off it was administered. Interview on 02/23/26 at 10:14 A.M. of Licensed Practical Nurse (LPN) #608 revealed on 10/30/25, Former Director of Nursing (FDON) #609 had to administer medications on the 400 nursing unit due to a nurse call-off. LPN #608 stated FDON #609 did not pass medications during the time she had the keys to the medication cart. LPN #608 stated he worked night shift and Resident #17 told him she did not receive her Oxycodone 5 mg at 2:00 P.M. as was ordered. LPN #608 indicated he checked Resident #17's MAR and found her Oxycodone was not signed off it was administered, and LPN #608 checked other residents on the nursing unit and found other residents did not receive medications during the time FDON #609 had the keys also. LPN #608 stated FDON #609 was always angry if she (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had to help out on the nursing units. Interview on 02/24/26 at 10:11 A.M. with Assistant Director of Nursing (ADON) #214 confirmed LPN #608 told her Resident's #17, #59, #66, #67 and #70 who resided on the 400 hall nursing unit did not have their medications signed off on their MAR's. ADON #214 stated she did not remember the date but when she was told about Resident's #17, #59, #66, #67 and #70 not receiving their medications it was way past time for her to leave for the day. LPN #214 stated she thought she told FDON #609 about it before she left, but it might have been the next day that she told FDON #609 that the residents did not receive their medications. ADON #214 stated she did not follow up on the residents not receiving their medications because she told FDON #609 about it. Interview on 02/24/26 at 4:00 P.M. of Regional Director of Clinical Services (RDCS) #301 and the Administrator confirmed there was no evidence on 10/30/25 on day shift that Resident's #17, #59, #66, #67 and #70 were administered their medications but they were unaware this occurred until now. RDCS #301 and the Administrator stated they had no knowledge of staff stating FDON #609 did not pass medications to the residents when she had to pass medications on a nursing unit. Review of the facility policy titled Medication Administration revised 01/17/23 included instructions to compare medication source with the MAR to verify resident's name, form, dose, route, and time of administration. Administer [medications] within 60 minutes prior to or after the scheduled time unless otherwise ordered by the physician. Administer the medication as ordered in accordance with manufacturer specifications. 6. Review of the medical record for Resident #33 revealed an admission date of 07/07/22. Diagnoses included hypertension, pain, anxiety disorder, aphasia, dysphasia and post traumatic seizures. Review of the October 2025 physician orders revealed Resident #33 had current orders for the following: tube feed to be held times one hour a day, resume tube feed at prescribed rate, flush with 50 ml of water prior to resuming; tube feed to be held times one hour daily, stop tube feed flush with 50 ml water prior to tube feed being turned off; Guaifenesin oral liquid (an expectorant)100 mg/5ml, give 20 ml via Percutaneous Endoscopic Gastrostomy (PEG) tube every 8 hours for congestion; Tylenol oral tablet 325 mg, give 650 mg via PEG-tube three times a day for mild pain/discomfort; enteral feed order every four hours flush tube 160 ml of water; Levetiracetam oral solution (an anti-seizure medication)100 mg/ml, give 5 ml via PEG-tube two times a day related to post traumatic seizures; enteral feed order, every day shift flush tube with 30 ml water before and after medication administration and feedings; enteral feed order every day shift, check residual every shift and record if residual greater than 150 ml, hold feeding and notify physician. Review of the October 2025 Medication Administration Record (MAR) revealed the following orders were not administered to Resident #33 on 10/16/25: enteral feed order every 4 hours flush tube 160 ml water at 5:00 P.M.; Tylenol oral tablet 325 mg, give 650 mg via PEG-tube three times a day for mild pain/discomfort at 1:00 P.M.; Guaifenesin oral liquid 100 mg/5ml, give 20 ml via PEG-tube every 8 hours for congestion at 2:00 P.M.; Levetiracetam oral solution 100 mg/ml, give 5 ml via PEG-tube two times a day related to post traumatic seizures at 6:00 P.M.; Tube-feed to be held times one hour daily one time a day, resume tube-feed at prescribed rate, flush with 50 ml of water prior to resuming at 3:00 P.M.; tube-feed to be held times one hour daily one time a day, stop tube-flush with 50 ml water prior to tube-feed being turned off at 2:00 P.M.; enteral feed order every day shift flush tube with 30 ml of water before and after medication administration and feedings at 7:00 P.M.; and enteral feed order every day shift check residual every shift and record if residual greater than 150 ml, hold (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding and notify MD at 7:00 P.M. Interview and review of the MAR on 02/24/26 at 2:34 P.M. with Licensed Practical Nurse #214 verified the above orders were not marked on the MAR as being completed. This deficiency represents non-compliance investigated under Complaint Number 2647655 and 2659281.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure resident room refrigerators were monitored, cleaned and outdated food items were disposed of appropriately. This affected five residents (#18, #39, #45, #55, and #59) of six residents whose room refrigerators were observed. The facility identified 13 residents (#1, #15, #18, #28, #35, #38, #39, #43, #45, #48, #55, #59 and #60) who had in-room refrigerators. The facility census was 55.Findings include: Interview on 02/24/26 at 10:42 A.M. with District Foodservice Manager #302 revealed the food service department was managed by a contracted agency and their staff do not go into resident rooms. District Foodservice Manager #302 was unsure if the facility had resident refrigerators or unit refrigerators since their department does not monitor them.1. Review of the resident record for Resident #18 revealed and admission date of 02/04/23. Diagnoses included but were not limited to anoxic brain damage, congestive heart failure, and vascular dementia. Resident #18 was noted to receive a no added salt diet. Review of the 02/14/26 Quarterly Minimum Data Set (MDS) 3.0 for Resident #18 revealed a Brief Interview of Mental Status (BIMS) of 13 which indicated intact cognition. Resident #18 was noted to require set up assistance for meals. Observation on 02/24/26 at 11:06 A.M. with admission Coordinator #207 of Resident #18's refrigerator revealed two one-ounce (oz) packets of sour cream with a use by date of 02/16/26, an 18 oz jar of black raspberry jam with the a use by date of 01/20/26, a 32 oz jar of pickled cauliflower with visible mold inside the jar with no evident use by date on the jar nor an open date, a half-pound open package of chopped deli ham with a use by date of 02/19/26, and another half-pound open package of chopped deli ham with a use by date of 02/06/26.2. Review of the resident record for Resident #39 revealed an admission date of 04/19/21. Diagnoses included but were not limited to chronic obstructive pulmonary disease, cardiomyopathy, and morbid obesity. Resident #39 was noted to receive a controlled carbohydrate diet. Review of the 01/24/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #39 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. Resident #39 was noted to require set up assistance for meals. Observation on 02/24/26 at 11:11 A.M. with admission Coordinator #207 of Resident #39's refrigerator revealed one 14 oz bottle of mustard with a use by date of 12/03/25. Interview at the time of observation with Resident #39 revealed staff checks the refrigerator frequently but was unsure if food expiration dates were checked. 3. Review of the resident record for Resident #55 revealed an admission date of 02/20/15. Diagnoses included but were not limited to Alzheimer's disease, cerebrovascular disease, dementia in other diseases, hemiplegia, and type II diabetes mellitus. Resident #39 was noted to receive a regular diet. Review of the 02/08/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #55 revealed a Brief Interview of Mental Status (BIMS) 3.0 of 12 which indicated moderate cognitive impairment. Resident #39 was noted to require set up assistance for meals. Observation on 02/24/26 at 11:14 A.M. with admission Coordinator #207 revealed Resident #55's room refrigerator had multiple dried stains in the refrigerator and was not clean. 4. Review of the resident record for Resident #59 revealed an admission date of 01/30/26. Diagnoses included but were not limited to type II diabetes mellitus, Alzheimer's dementia and obesity. Resident #59 was noted to receive a regular diet. Review of the 02/08/26 Significant change Minimum Data Set (MDS) 3.0 for Resident #59 revealed a Brief Interview of Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. Resident #59 was noted to require set up assistance for meals. Observation on 02/24/26 at 11:23 A.M. with admission Coordinator #207 revealed Resident #59's refrigerator was dirty with multiple dried stains on the inside.5. Review of the resident record for Resident #45 revealed and admission date of 11/27/24. Diagnoses included but were not limited to mononeuropathy of bilateral lower limbs, and epilepsy. Resident #45 was noted to receive a regular diet. Review of the 02/02/26 quarterly Minimum Data Set (MDS) 3.0 for Resident (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#45 revealed a Brief Interview of Mental Status (BIMS) of 15 which indicated intact cognition. Resident #59 was noted to require set up for meals. Observation on 02/24/26 at 11:30 A.M. with admission Coordinator #207 revealed Resident #45's refrigerator revealed it was dirty with multiple dried stains, contained a 14 oz squeeze bottle of mayonnaise with a use by date of 02/16/26, a 24 oz jar of sliced dill pickle spears with a use by date of 09/16/25, an open package of American cheese slices with five slices with a use by date of 02/21/26, and an opened and undated 16 oz container of spinach/artichoke dip with a use by date of 10/10/25.Interview at the time of the observation with Resident #45 revealed staff check the refrigerator temperature almost daily, but do not clean it. Resident #45 stated there are multiple dried spills on the bottom in the in the drawer but due to being in a wheelchair, he is unable to clean the refrigerator and staff do not offer to clean it, they just check the temperature.Interview with Admissions Coordinator #207 following observation the resident refrigerators listed above confirmed the above listed expired foods and cleanliness issues for the observed resident refrigerators.Interview on 02/25/26 at 8:08 A.M. with Transportation Staff #243 revealed he is responsible for checking the resident room refrigerator temperatures and sometimes he cleans the refrigerators. Transportation Staff #243 stated residents have reduced mobility and drop food in the refrigerator and if he sees the refrigerator is dirty, he cleans it. Transportation #243 stated sometimes residents tell him not to touch their food. A follow up interview on 02/25/26 at 1:28 P.M. with Transportation Staff #243 confirmed when a resident has told him not to touch or remove their food, he had not reported it to management for over a year.Review of the 07/01/25 revised facility policy called; Use and Storage of Food Brought in by Family or Visitors revealed it is the right of the residents of this facility to have food [NAME] in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident.All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative. The facility policy did not specify how frequently refrigerators would be cleaned or monitored.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, record review, and policy review, the facility failed to implement an effective antibiotic stewardship program. This affected 21 (#70, #25, #27, #50, #59, #15, #18, #22, #67, #49, #61, #19, #3, #4, #42, #16, #1, #43, #51, #34 and #7) residents of 55 residents in the facility with the potential to affect all residents residing in the facility. The facility census was 55.Findings Include:Review of the infection surveillance logs for November 2025 through January 2026 revealed the following residents did not meet McGreers criteria for antibiotic use and there was no documentation regarding what the facility did to find out why the criteria was not met: Resident #70 was diagnosed with a wound infection on 11/06/25 that was a Healthcare-Associated Infection and did not meet the criteria for antibiotic use. He was prescribed Cephalexin 500 milligrams (mg) twice a day from 11/06/25 through 11/13 25. No organism was reported. Resident #25 was diagnosed with a fungal skin infection (no area identified) on 11/06/25 and was classified as a Healthcare-Associated Infection which did not meet criteria for antibiotic use. The resident was placed on topical Nystatin to be applied twice a day beginning 11/05/25 through 11/10/25. The resident was also placed on Fluconazole 200 mg orally from 11/05/25 through 11/13/25 Resident #59 was diagnosed with Catheter Associated Urinary Tract Infection (UTI) on 11/09/25 and it was a Healthcare-Associated Infection and did not meet criteria for an antibiotic. No organism was identified. The resident was placed on Cefdinir 300 mg orally twice a day from 11/11/25 through 11/14/25. Resident #15 was diagnosed with a Catheter Associated UTI on 11/13/25 and was a Healthcare Associated Infection which did not meet criteria for an antibiotic. The resident was started on Meropenem 1 gram intravenously (IV) every eight hours from 11/20/25 through 11/27/25. Resident #18 was diagnosed with a skin (wound) infection in an unidentified area on 11/13/25 and did not meet criteria for antibiotic use. The wound was listed as a Healthcare Acquired Infection. The resident was started on Cephalexin 500 mg orally twice a day from 11/14/25 through 11/21/25. Resident #22 was diagnosed with an unidentified infection on 11/23/25. The infection site was listed as precautions that was a Healthcare-Associated Infection. The resident was placed on Cefdinir 300 mg orally twice a day and Bactrim DS 800-160 mg two times a day from 11/13/25 through 11/20/25 for both medications. Resident #67 was diagnosed with a symptomatic UTI on 11/18/25 that was a Healthcare-Associated Infection which did not meet criteria for an antibiotic. The resident was placed on Cephalexin 500 mg orally twice a day from 11/20/25 through 11/25/25. Resident #49 was started on a prophylactic antibiotic for a Community-Associated Infection and placed on Bactrim DS once a day from 11/20/25 through 12/04/25. No documentation was listed on the log regarding if the criteria were met for an antibiotic. Resident #61 was diagnosed with a Healthcare-Associated Infection of pneumonia on 11/26/25. Criteria for an antibiotic was not met. The resident was placed on Levofloxacin 500 mg orally one time a day from 11/27/25 through 12/03/25. No associated organism was listed. (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 19 was diagnosed with a throat infection on 11/26/26 and was a Healthcare-Associated Infection and did not meet criteria for antibiotic use. No organism was identified. The resident was placed on Augmentin 875-125 mg orally every 12 hours twice a day. Resident #3 was diagnosed with a symptomatic urinary tract infection (UTI) on 11/28/25 and was a Healthcare-Associate Infection (HAI). It did not meet criteria for an antibiotic. The organism was Enterobacter Cloacae. Cefdinir 300 milligrams orally every evening was ordered and was administered 12/5/25 through 12/22/25. Resident #42 was diagnosed with Pharyngitis on 12/03/25 and was a Healthcare Associate Infection that did not meet the criteria for antibiotic used. The resident was placed on Augmentin 875-125 mg orally every 12 hours from 12/03/25 through 12/10/25. Resident #4 was diagnosed with a symptomatic UTI on 12/04/25 and was a Healthcare Associated Infection that did not meet criteria for antibiotic use. Klebsiella Pneumoniae was identified as the organism causing the infection. The resident was started on Macrobid 100 mg orally twice a day from 12/08/25 through 12/18/25. Resident #16 was diagnosed with symptomatic UTI on 12/04/25 and was a Healthcare Associated Infection which not meet criteria for antibiotic use. The identified organism was Serratia Marcescens. The resident was placed on Cefdinir 300 mg orally twice a day from 12/09/25 through 12/16/25. Resident #1 was diagnosed with a fungal skin infection on 12/05/25 and was a Healthcare Associated Infection that did not meet the criteria for antibiotic use. The resident was started on Fluconazole 150 mg every 72 hours from 12/04/25 through 12/13/25. The resident was also started on Nystatin Powder 1,000,000 units per gram 1000 mg twice a day from 12/03/25 through 12/17/25. Resident #43 was diagnosed with a Catheter Associated UTI on 12/05/25 and was a Healthcare Associated Infection that did not meet criteria for antibiotic use. The resident was started on Cefpodoxime Proxetil 200 mg twice a day from 12/15/25 through 12/19/25 and was started on a second round from 12/23/25 through 12/28/25. Resident #70 was diagnosed with a wound infection on 12/15/25 and was a Healthcare Associated Infection that did not meet the criteria for antibiotic use. The organism identified was Pseudomonas Aeruginosa. The resident was started on Ceftriaxone 2 grams/50 milliliters (ml) of dextrose solution every evening from 12/25/25 through 01/03/26. The resident also was started on Ceftazidime 2 grams per 50 ml dextrose solution once a day from 12/24/25 through 12/25/25. Resident #51 was diagnosed with a fungal skin infection on 12/18/25 and was a Healthcare Associated Infection that did not meet the criteria for antibiotic use. Nystatin cream 1,000,000 units per gram 1% was ordered to be applied twice a day from 12/18/25 through 01/01/26. Resident #19 was diagnosed with a skin infection of the throat on 12/18/25 and was a Healthcare Associated Infection that did not meet criteria for antibiotic use. The resident was started on Augmentin 875-125 mg orally every 12 hours from 12/18/25 through 12/28/25. Resident #34 was diagnosed with a wound infection on 12/18/25 and was a Healthcare Associated Infection that did not meet criteria for antibiotic use. No organism was identified. Doxycycline 100 mg orally twice a day form 12/18/25 through 12/19/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 was diagnosed with a skin infection of the throat on 12/23/25 and was a Healthcare Associated Infection which not meet criteria for antibiotic use. The resident was started on Azithromycin 250 mg orally once a day from 12/25/25 through 12/29/25 as well as a one time dose on 12/24/25. Resident #67 was diagnosed with a UTI on 12/31/25 and was a Healthcare Associated Infection that did not meet criteria for an antibiotic. No organism was identified. The resident was started on Cephalexin 500 mg orally twice a day from 12/31/25 through 01/03/26. Resident #22 was diagnosed with an unknown infection labeled Precautions and was a Healthcare Associated Infection that was not marked as meeting criteria for antibiotic use or did not meet criteria for antibiotic use. Organism was listed as other. The resident was started on Cefdinir 300 mg orally twice a day from 12/31/25 through 01/07/26. The resident was also placed on Bactrim DS from 12/31/25 through 01/07/26. Resident #22 was diagnosed with a wound infection on 01/01/26 and was a Healthcare Associated Infection which did not meet criteria for antibiotic use. The organism was Klebsiella Pneumoniae. The resident was started on Vancomycin 250 mg per 5 ml four times a day on 01/09/26 then started again on 01/17/26 through 01/24/26. The resident also received Ertapenem Sodium 1 gram once a day from 01/08/26 through 01/18/26. Resident #50 was diagnosed with a skin infection to the throat on 01/02/26 which was a Healthcare Associated Infection and did not meet criteria for antibiotic use. The resident was started on Amoxicillin 500 mg three times a day from 01/02/26 through 01/09/26. Resident #67 was diagnosed with a wound infection on 01/08/26 and was a Healthcare Associated Infection which did not meet criteria for antibiotic use. No organism was identified. The resident was started on Metronidazole 500 mg every night shift from 01/09/26 through 01/16/26. Resident #43 was diagnosed with catheter associated UTI on 01/09/26 and was a Healthcare Associated Infection that did not meet criteria for antibiotic use. The identified organism was Enterococcus Faecium and was placed on Linezolid 600 mg orally twice a day from 01/12/26 through 01/22/26. Resident #61 was diagnosed with Cellulitis to an unknown location on 01/13/26 and was a Healthcare Associated Infection which not meet criteria for antibiotic use. The resident was started on Doxycycline 100 mg orally twice a day from 01/20/26 through 02/06/26. The resident also received Cephalexin 500 mg orally four times a day from 01/14/26 through 01/19/26. Resident #27 was diagnosed with a symptomatic UTI on 01/13/26 and was a Healthcare Associated Infection which did not meet criteria for antibiotic use. The identified organism was Escherichia Coli. The resident was started on Cefdinir 300 mg two times a day from 01/12/26 through 01/19/26. An interview with RDCS #301 on 02/25/26 at 4:05 P.M. confirmed the findings on the infection surveillance logs for November 2025 through January 2026. RDCS #301 revealed the reason there were so many residents who were marked did not meet McGeers criteria was due to staff not documenting or assessing the residents symptoms related to the infection. RDCS #301 stated they have begun education of the staff regarding what needs to be documented. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Antibiotic Stewardship Program policy, last revised 12/13/23, revealed the antibiotic stewardship program is part of the facility's overall infection prevention and control program. The purpose is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The Infection Preventionist coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff. The Medical Director serves as the primary medical point of contact for the program and serves as a liaison between the facility and other medical staff members. The Consultant Pharmacist reviews the antibiotics prescribed to the residents during their medication regimen review and serves as a resource for questions related to antibiotics. The program includes antibiotic use protocols and a system to monitor antibiotic usage. The nursing staff evaluates residents who are suspected to have an infection. Laboratory testing shall be in accordance with current standards of practice. The facility uses McGeer's Criteria to define infections. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. Prescriptions for antibiotics must specify the dose, duration, and indication for use. The facility will monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. All antibiotic orders will be reviewed for appropriateness. Monitor during each monthly medication regiment review when the resident has ben prescribed or is taking an antibiotic regimen review as requested by the Quality Assurance committee. Antibiotic use shall be measured by monthly prevalence, antibiotic starts, and/or antibiotic days of therapy. At least one outcome measure associated with antibiotic use will be tracked as part of the Quality Assurance program monthly.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the facility self-reported incidents (SRIs) facility policy review, the facility did not ensure a thorough investigation was completed for Resident #7 for an allegation of misappropriation and Resident #67 for an allegation of staff-to-resident physical abuse. This affected two resident (#7 and #67) of the four residents reviewed for abuse. The census in the facility was 55.Findings include:1. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including morbid obesity, peripheral vascular disease, major depressive disorder, gastroesophageal reflux disease, chronic pain, hypertension, insomnia, and hypothyroidism. Review of the Quarterly Minimum Data Set (MDS) 3.0 for Resident #7 dated 01/03/26 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. Review of the care plan dated 11/18/25 revealed Resident #7 required one person assist for bathing, bed mobility, dressing, personal hygiene, toileting, and a two person assist for transfers. Review of the facility SRI tracking number 268983 filed on 12/23/25, revealed on 12/22/25, Resident #7 made an allegation of misappropriation. The resident stated she was missing 15 dollars. She was unsure of when it went missing stating sometime between now and two weeks ago. Registered Nurse (RN) #247 reported the incident to the Director of Nursing (DON) on 12/22/25, and she told RN #247 to write a statement and have the resident do the same. Review of the SRI revealed there were no other staff interviews to review. The facility conducted interviews of all interviewable residents in the 200 hall, and all reported no money was missing from their room. The facility reimbursed the missing money and reminded Resident #7 to utilize her lock box in her room. The facility concluded as a result of its investigation that the misappropriation was unsubstantiated. Review of the staff statement dated 12/22/25 from RN #247 revealed around 9:45 P.M. Resident #7 informed RN #247 she thought 15 dollars was stolen from her room. Resident #7 told the nurse she normally has her wallet pinned to her shirt, but when she showers, she removes it and leaves it on her bedside table. Resident #7 said the last time she checked her coin purse was about two weeks prior to reporting the incident. RN #247 immediately reported the incident to the DON at 9:46 P.M. The DON informed her to write a statement and have the resident write one as well and place it under the DONs office door. Review of the Social Service progress note dated 12/23/25 at 1:28 P.M. revealed an interview with Resident #7 who noticed 15 dollars missing on 12/22/25, but stated it was last visualized two weeks earlier. The resident does have a lock box in her room, but she stated she had not utilized it as of late. Interview on 02/23/26 at 10:00 A.M. with the Administrator revealed that she was still waiting for a response from the previous Administrator regarding other staff interviews. (She reached out to the previous administrator to see if there were staff interviews for SRI tracking number 268983). A follow-up interview on 02/23/26 with the Administrator at 1:15 P.M. confirmed she had no other information or evidence to provide. Review of the facilities Abuse, Neglect, and Exploitation policy, revised on 01/10/24, revealed in section IV number 4. Identify and interview all involved people, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Section IV number 5. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide complete and thorough documentation of the investigation. 2. Review of Resident #67's medical record revealed an admission date of 07/18/25 and a discharge date of 01/13/26. Resident #67's diagnoses included unspecified convulsions, multiple fractures of the pelvis with stable disruption of the pelvic ring, initial encounter for closed fracture, and obesity. Review of Resident #67's care plan dated 07/18/25 included Resident #67 had an impaired musculoskeletal status related to recent back surgery. Resident #67 would be free of complications related to the altered musculoskeletal status through the next review. Interventions included to encourage Resident #67 to take her time to complete tasks and do not rush. Review of Resident #67's progress notes dated 08/14/25 at 4:10 P.M. included Resident #67 made an allegation of abuse regarding rough care during incontinence care. The allegation was reported to the State Agency and an investigation was initiated. Resident #67 was very thankful. Resident #67's responsible party and the Nurse Practitioner (NP) were notified. Review of SRI tracking number #264034 dated 08/14/25 included Resident #67 made an allegation of physical abuse by facility staff and provided meaningful information when interviewed. Resident #67 stated the incident occurred on 08/13/25 at 9:50 P.M. in her room. Resident #67 told the Speech Therapist (ST) that staff rushed her during incontinence care. Resident #67 stated staff flipped her, and she was sliding and it hurt her. Certified Nursing Assistant (CNA) #606 was suspended pending an investigation. CNA #607 was also present and was questioned. CNAs #606 and #607 stated Resident #67 expressed she was having pelvic pain, but she did not voice complaints regarding the care. CNA #607 stated Resident #67 asked them to slow down, so the CNA's kept pausing to give Resident #67 time to adjust, but she did not ask them to stop or say the care was rough. The allegation of abuse was unsubstantiated. Residents were questioned regarding abuse and neglect, and residents unable to be interviewed were provided with skin checks. (Note: the SRI did not include evidence that additional residents were interviewed and did not provide evidence that residents unable to be interviewed were provided with skin checks). Resident #67's skin assessment stated there were no new abnormal skin areas. There were no additional skin checks provided. The SRI did not include evidence that the nurse who was assigned to Resident #67 during the time of the alleged abuse was interviewed or wrote a witness statement. There was no evidence additional staff were interviewed or wrote witness statements related to Resident #67's allegation of abuse. Review of Resident #67's witness statement dated 08/14/26 included the aides woke Resident #67 up to change her, and she was fast asleep. It was 9:50 P.M., and they said they had to change her. One lady said Resident #67 was too slow, grabbed her and flipped her, and she was sliding out of bed, but they grabbed her before she hit the floor. It was so painful. Resident #67 stated the aides were CNA #607 and a younger girl. Resident #67 asked why are you hurting me, and they stated they had to hurry. CNA #607's witness statement dated 08/14/25 included when Resident #67 was rolled over to complete care, she complained of hip pain. CNA #607 wrote they kept pausing during Resident #67's care, and Resident #67 did not tell them to stop or voice concerns with the care. CNA #606's witness statement dated 08/14/25 included CNA s #606 and #607 provided Resident #67's care, she was turned and she said her hip hurt a little, and when she was turned onto her back the pain resolved. CNA #606 wrote they did not indicate she was too slow, and Resident #67 did not indicate the aides were rough. Review of Resident #67's progress notes dated 08/15/25 at 9:51 A.M. included Resident #67 was sitting in bed eating breakfast. Resident #67 smiled, demonstrated appropriate affect, maintained eye contact and engaged in conversation. Resident #67 denied concerns concerning her physical, emotional, psychological and social well-being. Resident #67 denied fear or concerns regarding her safety. Resident #67 stated I know nobody tried to hurt me. Resident #67 denied need for additional services. Review of Resident #67's Quarterly MDS assessment dated [DATE] included Resident #67 had moderate cognitive impairment. Resident #67 was dependent on staff for toileting hygiene and bathing. Resident #67 was always incontinent of bowel and bladder. Interview on 02/24/26 at 1:42 P.M. of Assistant Director of Nursing (ADON) #214 revealed she was told by the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	former DON to get witness statements from CNA #606 and #607 regarding Resident #67's allegation of abuse. ADON #214 indicated the ST gave her Resident #67's written statement, and she gave the witness statements to the former DON and the former Administrator. ADON #214 stated she did not complete skin assessments of additional residents and confirmed she did not interview other residents related to the allegation of physical abuse. ADON #214 stated CNAs #606 and #607 no longer worked at the facility. Interview on 02/24/26 at 2:40 P.M. of Regional Director of Clinical Services (RDCS) #301 revealed she spoke with Resident #67 about her allegation that CNA #606 was rough with her. RDCS #301 stated she talked to Resident #67 to gather more information, and the former DON did the investigation. RDCS #301 indicated she did not have additional information related to the investigation and confirmed there was no evidence additional residents, nurses or other staff were interviewed and no evidence they wrote witness statements. Review of the facility policy titled Abuse, Neglect and Exploitation, revised 01/10/2024, included investigation of alleged abuse, neglect and exploitation included identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Providing complete and thorough documentation of the investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and job description review, the facility failed to ensure Resident #5 received a complete dietary assessment. This affected one resident (#5) of three residents reviewed for nutritional assessments. The facility census was 55.Findings include:Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, gastric reflux, high blood pressure, atrial fibrillation, and heart disease. The resident was admitted to the secured dementia unit.Review of the weights for Resident #5 revealed upon admission on [DATE] the resident's weight was 190.8 pounds. The most recent weight obtained on 02/12/26 was 189.0 pounds.Review of the physician's order for Resident #5 revealed on 12/17/25 an order was written for a regular diet, regular texture, and thin liquids.Review of Resident #5's assessments revealed a Nutrition Data Collection/Evaluation-V2 was completed on 12/18/25 by Former Registered Dietitian (FRD) #304 revealed the diet order was a regular diet, regular texture, regular fluid, thin consistency. His height was 69 inches, and his weight was 190.8 pounds. No updated labs were available for FRD #304 to review. The resident's caloric needs per day were 1740 to 2610 calories. His protein needs were 87 grams to 104 grams per day. His fluid needs were 2610 milliliters per day. FRD #304 recommended to continue with his current nutrition plan of care and will continue to monitor diet, intake, weight, labs, skin concerns, medications and nutritional status. FRD #304 added a comment of went to speak with resident and door was shut with enhanced barrier precautions. Please speak to resident for follow up. Enhanced Barrier Precautions (EBP) are infection control measures in nursing homes, requiring gown and glove use during high-contact care for residents with chronic wounds, indwelling devices, or known multidrug-resistant organisms to help prevent further transmission to others. No other dietary assessments were completed.Review of the nursing progress notes for Resident #5 revealed no dietary progress notes had been documented since admission.Review of the job description for the facility registered dietitian revealed the dietitian is required to complete comprehensive nutrition assessments, including comprehensive Minimum Data Set (MDS) assessments, assessing residents and developing care plans in accordance with federal and state regulatory guidance. The dietitian consults with residents, families, or the interdisciplinary team as needed regarding the plan of care for residents. The dietitian reviews therapeutic and regular diet plans and menus to ensure that they are in compliance with the physician's orders. Interview with Regional Director of Clinical Services (RDCS) #301 on 02/25/26 at 2:00 P.M. confirmed she was unable to find any other dietary assessments for Resident #5. FRD #304 was the prior dietitian for the facility and was released from her contract. RDCS #301 said she had no idea why FDR #304 would not enter a room where a resident was on EBP precautions. Registered Dietician (RD) #303 started working for the facility approximately three weeks earlier, will be in the facility on 02/26/26, and will assess Resident #5 upon arrival. RD #303 had not assessed the resident since she assumed the dietitian position.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, interview and policy review, the facility failed to ensure a comprehensive care plan was completed for one resident (#24) of 32 residents reviewed for care plans. The facility census was 55.Findings include: Review of medical record for Resident #24 revealed an admission date of 07/02/25. Diagnoses included but were not limited to Alzheimer's dementia, dementia with behaviors, type II diabetes mellitus, oppositional defiant disorder and depression.Review of the 01/08/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #24 revealed a Brief Interview of Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. Resident #24 was noted to feel down, have trouble falling asleep, and had a poor appetite during 12 to 14 days during the 14-day review period. Resident #24 was noted to require supervision for most activities of daily living and moderate assistance for bathing. Resident #24 was also noted to receive antipsychotic, antianxiety, and antiplatelet medications.Review of Resident #24's care plan which was last reviewed on 01/22/26 revealed no evidence of a care plan for monitoring of an antipsychotic, antidepressant, or anticoagulant medications or interventions.Interview on 02/25/26 at 3:15 P.M. with the Director of Nursing (DON) confirmed she was unable to provide evidence of an antipsychotic, anticoagulant, or antidepressant care plan for Resident #24 as required. Review of the 06/30/22 revised facility policy called Comprehensive Care Plans revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. (Minimum Data Set).

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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** Based on observations, interviews, record review, and policy review the facility failed to ensure staff did not assist Resident #5 with exiting the secured dementia unit without verifying he was a resident. In addition, the facility failed to ensure safe smoking interventions were in place for Resident #55 during an observed smoking activity. This affected two residents (Resident #5 and #55) of three residents reviewed for accidents. The facility identified eight residents (Resident #14, #38, #42, #44, #49, #51, #53, and #55) who smoked. The facility census was 55.Findings Include: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, gastric reflux, high blood pressure, atrial fibrillation, and heart disease. The resident was admitted to the secured dementia unit. Review of the physician orders revealed no order for the resident to reside on the secured dementia unit. Review of the 12/16/25 nursing admission assessment under Risk of Elopement/Wandering assessment revealed the resident was not cognitively impaired, with poor decision making skills. The resident was assessed to not have a diagnosis of dementia, organic brain syndrome, Alzheimer's Disease, hallucinations, or anxiety. No unsafe behaviors were assessed at present. The resident was admitted to the secured dementia unit. No admission baseline care plan for elopement was initiated. Review of Resident #5's comprehensive admission Minimum Data Set (MDS) 3.0 assessment, dated 12/23/25, revealed the resident was moderately cognitively impaired, had no behaviors, and was independently mobile Review of Housekeeping (Hskg) #285's written statement, dated 12/20/25, revealed he was assigned to clean three units, one of which was the secured dementia unit. The first unit he cleaned was the secured dementia unit. When he attempted to exit the unit, he saw a gentleman standing near the exit door carrying a suitcase. Hskg #285 had not seen Resident #5 before and believed him to be a guest or visitor. The resident appeared calm and composed and politely asked to be let out. The resident spoke clearly and appropriately. Hskg #285 unlocked the door and allowed the resident to exit and then returned to his duties. Review of the written statement dated 12/20/25 from Certified Nursing Assistant (CNA) #204 revealed the incident occurred on 12/20/25. Resident #5 exited the secured dementia unit after Housekeeping (Hskg) #285, who was unaware the residents on the unit were not permitted to leave unless with a staff member of the unit. Resident #5 had been demonstrating exit seeking behaviors, pacing the hallway with a suitcase, going back and forth from room to door stating I need to get to the airport. At approximately 2:28 P.M. Resident #5 was seen exiting the unit and started heading toward the nurses' station. CNA #204 noticed the resident and called for help and returned the resident to the secured dementia unit. The statement revealed the elopement was reported on 12/20/25 to the charge nurse but the Director of Nursing (DON) was not notified until 12/21/25. The DON then notified the Medical Director. The camera footage from the unit was reviewed on 12/22/25 and showed Hskg #285 opened the door and allowed the resident to exit the unit. Review of the nursing progress notes revealed on 12/21/25 at 12:07 P.M. Licensed Practical Nurse (LPN) #265 was informed Resident #5 had followed someone out the door of the secured unit (while (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was) carrying a suitcase and stating he had to go to the airport. The resident was helped back down the hallway to the memory care unit. The doctor and the resident's daughter were aware of the incident. There was no mention of exit seeking behavior or the resident exiting the secured unit on 12/20/25. Interview with the Administrator on 02/23/26 at 4:45 P.M. verified the resident did leave the secured unit because Hskg #285 let him out since they didn't know he was a resident on the secured unit. The Administrator verified staff returned the resident to the secured unit immediately. Review of the facility's Unsafe Wandering & Elopement Prevention policy, last revised 01/01/2022, revealed all residents who are at risk for harm because of unsafe wandering will be assessed by the Interdisciplinary Team (IDT). The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Interventions for unsafe wandering and elopement attempts will be entered onto the resident's care plan and medical record. Should an elopement episode occur, the contributing factors as well as the interventions tired, will be documented in the nurses' notes. Review of the facility's undated Memory Care Unit admission Determination policy revealed when determining if an individual will be admitted the facility takes into account the specific care needs of the individual and if the facility can meet those needs; the physical characteristics of the facility and its capacity to meet the identified needs; the staffing level and skill of unit personnel to meet the individual's needs; and the overall clinical stability of the resident's current condition. The admission Committee reviews the pre-admission paperwork/referral for admission determination. The committee includes but is not limited to the program director, the DON/Unit Manager, Social Service Director, the Admissions Coordinator, and the Administrator. 2.Record review of Resident #55 revealed an admission date of 02/20/2015. Diagnosis included but were not limited to Alzheimer's disease, transient ischemic attack and cerebral infarction. Review of Resident #55 care plan with a revision date of 1/12/26 revealed Resident #55 must wear a smoking apron (while smoking). Review of smoking assessment dated [DATE] and 02/17/26 revealed that Resident #55 should have a smoking apron on while smoking. Smoking assessment also revealed Resident #55 was not able to safely light her cigarettes and needed a smoking aide while smoking. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #55 Brief Interview of Mental Status (BIMS) was a 12 which indicated moderate cognitive impairment. Resident #55 was noted to be dependent for Activities of Daily Living (ADLs). On 02/17/26 at 11:05 A.M. an observation was done during the 11:00 A.M. smoke time. Residents in attendance were #14, #38, #42, #44, #49, #51, #53, and #55. There were two activity assistants monitoring the smoking break, Activity Assistant #201 and #209. Resident #55 was observed smoking without an apron and was received cues from the aides to ash (place her ashes from the cigarette in the ashtray) her cigarette. Interview with Resident #55 revealed no concerns with the smoking activity. On 02/17/26 at 11:15 A.M. an interview with Activity Assistant #201 revealed that she didn't know if Resident #55 should be wearing an apron. On 02/17/26 at 2:55 P.M. an interview with the Administrator confirmed that Resident #55 should (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been wearing an apron while smoking. Review of the 12/31/25 facility policy called Smoking Policy Smoking Campus-Residents revealed it is the policy of the facility to establish and maintain safe resident smoking practices. Under smoking times number four indicated that any person of person providing smoking supervision to residents must be instructed in smoking regulation prior to rendering such service.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, incident review and facility policy review, the facility failed to ensure sufficient supervision was maintained to prevent Resident #5 from exiting the secured dementia unit. This affected one resident (#5) of two residents reviewed for dementia care. The facility census was 55. Findings include:Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, gastric reflux, high blood pressure, atrial fibrillation, and heart disease. The resident was admitted to the secured dementia unit.Review of the nursing admission assessment dated [DATE] revealed the Risk of Elopement/Wandering assessment revealed Resident #5 was not cognitively impaired with poor decision making skills. The resident was assessed to not have a diagnosis of dementia, organic brain syndrome, Alzheimer's Disease, hallucinations, or anxiety. No unsafe behaviors were assessed as present. The resident was admitted to the secured dementia unit. No admission baseline care plan for elopement was initiated.Review of the written statement dated 12/20/25 from Certified Nursing Assistant (CNA) #204 revealed an incident occurred on 12/20/25. Resident #5 exited the secured dementia unit after Housekeeping (Hskg) #285 who was unaware the residents on the unit were not permitted to leave unless they were with a staff member of the unit. Resident #5 had been demonstrating exit seeking behaviors, pacing the hallway with a suitcase, going back and forth from room to door and stating, I need to get to the airport.Review of Hskg #285's written statement dated 12/20/25 revealed he was assigned to clean the secured dementia unit. When he exited the unit, he saw a gentleman standing near the exit door carrying a suitcase. Hskg #285 had not seen Resident #5 before and believed him to be a guest or visitor. The resident appeared calm and composed and politely asked to be let out. The resident spoke clearly and appropriately. Hskg #285 unlocked the door and allowed the resident to exit and then returned to his duties.Review of the nursing progress notes revealed on 12/21/25 at 12:07 P.M. Licensed Practical Nurse (LPN) #265 was informed Resident #5 had followed someone out the door of the secured unit carrying a suitcase and stating he had to go to the airport. The resident was helped back down the hallway to the memory care unit. The resident's daughter was notified of the incident. No documentation was located regarding Resident #5's exit seeking behaviors on 12/20/25. The Director of Nursing (DON) was not notified by staff of Resident #5 leaving the secured dementia unit until 12/22/25. The DON notified the medical director and the administrator on 12/22/25.Review of Resident #5's comprehensive admission Minimum Data Set (MDS) 3.0 assessment, dated 12/23/25, revealed the resident was moderately cognitively impaired, had no behaviors, and was independently mobile.Review of the care plans for Resident #5 revealed an elopement care plan was initiated on 12/29/25 due to the resident's exit seeking behavior. Interventions put in place to deal with his exit seeking behaviors were to redirect and divert the resident's attention, distract the resident when he was wandering/insistent on leaving the facility by offering pleasant diversions, structured activities, food, conversation, television, books, etc. The resident was to be evaluated for the need for a Wanderguard (a device that prevents an exit seeking resident from being able to leave the facility), and to promptly check when the alarm system goes off to ensure the resident was safe and remained in the facility.Observation of the secured unit on 02/17/26 at 10:57 A.M. revealed the ventilator unit hallway led to the secured dementia unit. A code had to be entered to access the common area of the secured dementia unit. The nurses' station was located in the common area and a hall leading out of the common area is where the residents' rooms were located. The residents' rooms were unable to be observed from the common area. The end of the hallway exits to the rest of the nursing area. A code must also be entered to exit the unit.Interview with the Administrator on 02/19/26 at 3:15 P.M. revealed Resident #5 did not elope; he just left the secured dementia unit on 12/20/25, and staff immediately returned him to the unit. The investigation (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the resident leaving the unit was requested and what measures were put into place to prevent future occurrences. The Administrator said they did a past noncompliance investigation on 12/21/25 along with audits after the incident. The Administrator again stated the resident did not elope as he did not leave the facility. All staff were educated on elopement including housekeeping and laundry as they are a contracted service. Interview with the Administrator on 02/23/26 at 4:45 P.M. revealed they chose not to add a Wanderguard to Resident #5's plan of care because he resides on the secured unit. The resident did manage to leave the unit because Hskg #285 let him out because he looked and acted normal. The Administrator said the secured dementia unit was not set up to alarm when a Wanderguard was in use and a resident approached the secured dementia unit's exit. The Administrator confirmed the unit does not necessarily need to be wired to the alarm, but for a resident new to the facility that staff may not recognize, it would prevent a resident from being able to exit the facility and keep the resident safe. The Administrator said she would have to take the idea to the corporate team. They have also included contracted staff to attend new employee orientation.Review of Hskg #285's dementia education revealed on 10/01/25 at 7:30 A.M. he watched a Dementia Overview video. No other information was available.Review of the facility's Unsafe Wandering & Elopement Prevention policy, last revised 01/01/2022, revealed all residents who are at risk for harm because of unsafe wandering will be assessed by the Interdisciplinary Team (IDT). The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Interventions for unsafe wandering and elopement attempts will be entered into the resident's care plan and medical record. Should an elopement episode occur, the contributing factors as well as the interventions tried, will be documented in the nurses' notes. Review of the facility's undated Memory Care Unit admission Determination policy revealed when determining if an individual will be admitted the facility takes into account the specific care needs of the individual and if the facility can meet those needs; the physical characteristics of the facility and its capacity to meet the identified needs; the staffing level and skill of unit personnel to meet the individual's needs; and the overall clinical stability of the resident's current condition. The admission Committee reviews the pre-admission paperwork/referral for admission determination. The committee includes but is not limited to the program director, the DON/Unit Manager, Social Service Director, the Admissions Coordinator, and the Administrator.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, interview, review of pharmacy recommendations, and policy review, the facility failed to ensure pharmacy recommendations were acknowledged and addressed timely for two residents (Residents #4 and #24) out of five reviewed for unnecessary medications. The facility also failed to monitor one resident (Resident #61) of two residents reviewed for blood glucose levels. The facility census was 55.Findings Include:1.Review of medical record for Resident #24 revealed an admission date of 07/02/25. Diagnoses included but were not limited to Alzheimer's dementia, dementia with behaviors, type two diabetes mellitus, oppositional defiant disorder and depression. Review of the 01/08/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #24 revealed a Brief Interview of Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. Resident #24 was noted to require supervision for most activities of daily living and moderate assistance for bathing. Resident #24 was also noted to feel down, have trouble falling asleep, poor appetite 12 – 14 of the 14-day review period and receive antipsychotic, antianxiety, and antiplatelet medications. a. Review of the 07/02/25 physician order for Resident #24 revealed an order for 200 milligrams (mg) oral tablet of Seroquel (generic form is Quetiapine Fumarate, an antipsychotic) to be given by mouth at bedtime for mood disorder. Review of the pharmacy recommendation dated 07/03/25 for Resident #24 revealed a recommendation for Seroquel plus Trileptal to add for behavior and side effect monitoring. The form did not have evidence of a completed date or physician signature. Review of the 07/02/25 physician order for Resident #24 revealed an order for one oral tablet of 150 mg of Trileptal (generic is Oxcarbazepine, an anticonvulsant) to be given by mouth two times a day for mood disorder. A second order dated 07/02/25 for Resident #24 revealed an order for one oral tablet of 75 mg Oxcarbazepine to be given by mouth two times a day for mood disorder. Review of the pharmacy recommendation dated 07/03/25 for Resident #24 revealed a recommendation for Seroquel plus Trileptal to add behavior and side effect monitoring. The form did not have evidence of a completed date or physician signature. Review of the 08/14/25 physician order for Resident #24 revealed an order to observe the resident closely for significant side effects of anti-psychotic medication and report to the physician. Side effects included but were not limited to seizures. b. Review of the 07/02/25 physician order for Resident #24 revealed an order to give 17 grams (gm) by mouth of MiraLAX (laxative used for constipation) oral Powder 17gm/scoop every 24 hours as needed for constipation. Review of the pharmacy recommendation dated 07/03/25 for Resident #24 revealed a recommendation to clarify the MiraLAX order to include administer with four to eight ounces of liquid. The form did not have evidence of a completed date or physician signature. Review of the 08/12/25 physician order for Resident #24 revealed an order to give 17 grams by mouth of MiraLAX oral Powder 17gm/scoop every 24 hours as needed for constipation. The order was (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated to administer with four to eight ounces of liquid. c. Review of the 07/03/25 physician order for Resident #24 revealed an order to give one 81 milligram tablet of aspirin by mouth one time a day for heart health. (The order was discontinued on 08/12/25.) Review of the pharmacy recommendation dated 07/06/25 for Resident #24 revealed a recommendation to clarify the order for aspirin tablet with instructions to give 81 mg by mouth one time a day. Recommendations were made to clarify the dosage formulation for low dose aspirin (i.e. chewable, enteric coated) in the order. Physician recommendation was signed on 08/12/25 with instructions to change to aspirin 81 milligram oral enteric coated tablet to be taken by mouth daily. Review of the 08/13/25 physician order for Resident #24 revealed an order to give one tablet by mouth of aspirin low dose oral tablet chewable 81 milligram one time a day related to chronic atrial fibrillation. The order was not for the enteric coated tablet. d. Review of the 07/02/25 physician order for Resident #24 revealed an order for a 12.5 milligram tablet of Coreg (generic is Carvedilol used to monitor blood pressure) by mouth one tablet twice daily. Review of the pharmacy recommendation dated 07/03/25 for Resident #24 revealed a recommendation for Coreg. Recommendation stated medication should be administered with meals. Please update administration times. The form did not have evidence of a completed date or physician signature. Review of the 08/12/25 physician order for Resident #24 revealed an order for 12.5 milligram tablet of Coreg by mouth one tablet twice daily with meals. e. Review of the 07/03/25 physician order for Resident #24 revealed an order to give 75 mg of Plavix (Generic is Clopidogrel Bisulfate, a blood thinner) oral tablet by mouth one time a day for cerebrovascular accident prevention. Review of the pharmacy recommendation dated 07/03/25 for Resident #24 revealed a recommendation for Plavix plus aspirin to add monitor for signs and symptoms of bleeding/bruising; monitor for thromboembolism. The physician gave a verbal order on 08/14/25. The form did not have evidence of a completed date or physician signature. Review of the 08/14/25 physician order for Resident #24 revealed an order to monitor signs and symptoms of bleeding/bruising every shift. For gross bleeding call 911. Review of the 09/27/25 physician order for Resident #24 revealed an order to give one 25 mg tablet of Zoloft (generic is Sertraline Hydrochloride used for depression) oral tablet by mouth one time a day related to dementia with behaviors. The order was discontinued on 11/19/25. Review of the pharmacy recommendation dated 10/29/25 for Resident #24 revealed a recommendation to clarify the diagnosis for the order for Zoloft (Sertraline Hydrochloride). The physician acknowledged the order on 12/02/25 to add a diagnosis of depression. Review of the 12/03/25 physician order for Resident #24 revealed an order to give one 25 mg tablet of Zoloft (Generic is Sertraline Hydrochloride) oral tablet by mouth one time a day for depression. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/23/26 at 3:51 P.M. with Regional Director of Clinical Services #301 confirmed the pharmacy recommendations for Resident #24 were not signed by the physician in less than 30 days. Review of the 12/28/23 revised facility policy titled, Addressing Medication Regimen Review Irregularities revealed it is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form. The attending physician must document in the resident 's medical record that the identified irregularity has been reviewed and what, if any, action, has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rational in the resident's medical record. The requirements associated with the MRR apply to all residents, whether short or long stay. The attending physician shall sign the form upon the next visit to the facility. 2. Resident #61 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, peripheral vascular disease, chronic obstructive pulmonary disease, diabetes, bipolar disorder with psychotic features, post-traumatic stress disorder, obstructive sleep apnea, morbid obesity, and was ventilator dependent. Review of the comprehensive Minimum Data Set (MDS) 3.0 comprehensive quarterly assessment dated [DATE] for Resident #61 revealed the resident was cognitively intact, took medication for diabetes. Review of the Self Med Administration assessment dated [DATE] revealed Resident #61 was able to identify the medications he was ordered and was able to state why he took the medication. The medications were assessed to kept in a secure, locked area. Review of the physician's orders for Resident #61 revealed staff were to observe resident for symptoms of both low blood sugar levels and high blood sugar levels. An order dated 04/04/25 indicated the resident may self administer his medication which are stored in a lock box in his room. Nurses were to validate administration and blood sugar readings with the resident as scheduled. An order dated 01/19/26 indicated the resident was to receive Humalog insulin per a sliding scale order based on his blood glucose level. The resident was to check his blood sugars before meals and at bedtime. Insulin was to be administered subcutaneously in the following amounts depending on the blood glucose level: 180 to 240: Administer two units of Humalog insulin 241 to 300: Administer four units of Humalog insulin 301 to 360: Administer six units of Humalog insulin 361 to 400: Administer eight units of Humalog insulin The orders further stated the resident may check his blood glucose levels and administer his own insulin unsupervised. The nurse must obtain from the resident his blood glucose level and how many units of insulin he administered and document the information in the medical record. The resident also had an order dated 02/17/26 for Mounjaro (a medication used to treat diabetes as well as for weight loss) 7.5 milligrams (mg)/0.5 milliliters (ml) injected subcutaneously once a week on Mondays for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	both diabetes and weight loss. Review of the Medication Administration Record (MAR) from December 2025 through February 2026 for Resident #61 revealed no documentation regarding the blood glucose levels or how much insulin was administered. Review of the vitals section of the electronic medical record for Resident #61 revealed blood glucoses were entered but were not entered four times a day as ordered by the physician. No documentation was entered as to how much insulin was administered by the resident. Interview with Regional Director of Clinical Services (RDCS) #301 on 02/23/26 at 5:05 P.M. confirmed nursing should be documenting Resident #61's blood glucose levels and the amount of insulin administered as ordered by the physician. Review of the facility's policy titled Addressing Medication Regimen Review Irregularities, last revised 12/28/23, revealed the pharmacist may identify and report irregularities in one or more categories including the use of a medication without evidence of adequate monitoring. 3.Review of the medical record revealed Resident #4 was admitted on [DATE]. Diagnoses include but not limited to dementia, psychotic disturbance, mood disturbance, anxiety, diabetes type two, chronic kidney disease, atrial fibrillation, hypothyroidism, ulcerative colitis, metabolic encephalopathy, alcohol dependence, and hypokalemia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired and required the assistance of supervision and some assistance completing activities of daily living. Review of the physician orders dated 04/09/25 for Resident #4 revealed an order for two capsules of 20 milligrams (mg) Omeprazole (a proton pump inhibitor medication) to be given by mouth once daily. Review of the pharmacist recommendation dated 09/22/25 revealed Resident #4 had a physician order dated 04/09/25 for medication Omeprazole 20 mg (medication used to treat gastroesophageal reflux disease, dose was two capsules by mouth one time a day) The pharmacist noted the resident was ordered a high dose of a proton pump inhibitor. The pharmacist recommended a dose reduction to 20 mg by mouth one time a day. Review of the pharmacy recommendation revealed the nurse practitioner agreed with the recommendation and signed it on 10/25/25. Review of the 11/2025 Medication Administration Record (MAR) for Resident #4 revealed the order for two 20 mg capsules daily of Omeprazole continued to be given until 11/05/25 when it was discontinued. Interview on 02/23/26 at 3:51 P.M. with the Regional Director of Clinical Services #301 confirmed the pharmacy recommendations for resident #4 were not signed by the physician in a timely manner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility investigation, the facility failed to ensure nursing documentation was accurate and contained information pertinent to resident care. This affected one resident, (Resident #5) of three residents reviewed for accidents. The facility census was 55. Findings Include:Resident #5 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, gastric reflux, high blood pressure, atrial fibrillation, and heart disease. The resident was admitted to the secured dementia unit.Review of the physician orders revealed no order for the resident to reside on the secured dementia unit.Review of the 12/16/25 nursing admission assessment under Risk of Elopement/Wandering assessment revealed the resident was not cognitively impaired, with poor decision making skills. The resident was assessed to not have a diagnosis of dementia, organic brain syndrome, Alzheimer's Disease, hallucinations, or anxiety. No unsafe behaviors were assessed at present. The resident was admitted to the secured dementia unit. No admission baseline care plan for elopement was initiated.Review of Resident #5's comprehensive admission Minimum Data Set (MDS) 3.0 assessment, dated 12/23/25, revealed the resident was moderately cognitively impaired, had no behaviors, and was independently mobileReview of Housekeeping (Hskg) #285's written statement, dated 12/20/25, revealed he was assigned to clean three units, one of which was the secured dementia unit. The first unit he cleaned was the secured dementia unit. When he attempted to exit the unit, he saw a gentleman standing near the exit door carrying a suitcase. Hskg #285 had not seen Resident #5 before and believed him to be a guest or visitor. The resident appeared calm and composed and politely asked to be let out. The resident spoke clearly and appropriately. Hskg #285 unlocked the door and allowed the resident to exit and then returned to his duties.Review of the written statement dated 12/20/25 from Certified Nursing Assistant (CNA) #204 revealed the incident occurred on 12/20/25. Resident #5 exited the secured dementia unit after Housekeeping (Hskg) #285, who was unaware the residents on the unit were not permitted to leave unless with a staff member of the unit. Resident #5 had been demonstrating exit seeking behaviors, pacing the hallway with a suitcase, going back and forth from room to door stating I need to get to the airport. At approximately 2:28 P.M. Resident #5 was seen exiting the unit and started heading toward the nurses' station. CNA #204 noticed the resident and called for help and returned the resident to the secured dementia unit. The statement revealed the elopement was reported on 12/20/25 to the charge nurse but the Director of Nursing (DON) was not notified until 12/21/25. The DON then notified the Medical Director. The camera footage from the unit was reviewed on 12/22/25 and showed Hskg #285 opened the door and allowed the resident to exit the unit.Review of the nursing progress notes revealed on 12/21/25 at 12:07 P.M. Licensed Practical Nurse (LPN) #265 was informed Resident #5 had followed someone out the door of the secured unit (while the resident was) carrying a suitcase and stating he had to go to the airport. The resident was helped back down the hallway to the memory care unit. The doctor and the resident's daughter were aware of the incident. There was no mention of exit seeking behavior or the resident exiting the secured unit on 12/20/25.Review of the facility's Unsafe Wandering & Elopement Prevention policy, last revised 01/01/2022, revealed all residents who are at risk for harm because of unsafe wandering will be assessed by the Interdisciplinary Team (IDT). The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Interventions for unsafe wandering and elopement attempts will be entered onto the resident's care plan and medical record. Should an elopement episode occur, the contributing factors as well as the interventions tired, will be documented in the nurses' notes.Review of the facility's undated Memory Care Unit admission Determination policy revealed when determining if an individual will be admitted the facility takes into account the specific care needs of the individual and if the facility can meet those needs; the physical (continued on next page)

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	365718	A. Building B. Wing	03/03/2026

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Arbors at Streetsboro	1645 Maplewood Dr Streetsboro, OH 44241

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characteristics of the facility and its capacity to meet the identified needs; the staffing level and skill of unit personnel to meet the individual's needs; and the overall clinical stability of the resident's current condition. The admission Committee reviews the pre-admission paperwork/referral for admission determination. The committee includes but is not limited to the program director, the DON/Unit Manager, Social Service Director, the Admissions Coordinator, and the Administrator.Interview with Regional Director of Clinical Services (RDCS) #301 on 02/25/26 at 2:00 P.M. confirmed LPN #265 should have documented Resident #5's exit seeking behaviors, carrying a suitcase around the unit, that he left the unit after Hskg #285 held the door open for him to leave, and that he was safely returned to secured dementia unit by staff not working on the secured unit on the same date as the incident occurred. RDCS #301 also confirmed the admission assessment should have reflected the resident's accurate information.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to collaborate care with hospice, complete a comprehensive assessment and implement care planned interventions for Resident #59 who experienced a change of condition. This affected one resident (Resident #59) out of three residents reviewed for hospice services. The facility census was 55.Findings include:Review of Resident #59's medical record revealed an admission date of 08/23/19 and diagnoses included chronic combined systolic (congestive) and diastolic (congestive) heart failure, type two diabetes mellitus with diabetic peripheral angiopathy without gangrene, Alzheimer's Disease, paroxysmal atrial fibrillation, dementia, and cardiomyopathy.Review of Resident #59's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had moderate cognitive impairment. Resident #59 used a wheelchair and required supervision or touching assistance for toileting and personal hygiene. Resident #59 required partial to moderate assistance with lower body dressing. Resident #59 had an indwelling catheter and was frequently incontinent of bowel.Review of Resident #59's After Visit Summary for a hospital admission [DATE] through 02/07/26 included in the medication list to administer insulin lispro 100 units per milliliter injection, inject zero to five units under the skin three times daily (morning, midday, late afternoon). Take as directed per insulin instructions. Resident #59 was discharged to the facility with hospice, continue Keflex for six more days, continue comfort measures per hospice, hypoglycemic protocol recommended and monitor for hypoglycemia.Review of Resident #59's progress notes dated 02/07/26 at 6:06 P.M. included Resident #59 arrived at the facility via stretcher accompanied by EMT's at approximately 4:45 P.M. Resident #59 was alert, responded to staff, but was very lethargic. Resident #59 did not have pain or signs and symptoms of discomfort. Resident #59 was given oxygen for comfort and Resident #59 was lying quietly with his eyes closed Hospice services were contacted and stated they would be at the facility on 02/08/26 to admit Resident #59 to hospice services.Review of Resident #59's Treatment Administration Record (TAR) dated 02/07/26 through 02/18/26 revealed if Resident #59's blood sugar was less than 70 administer OJ, food or glucose gel per manufacturer recommendations, recheck in 15 minutes, if no improvement notify the physician, every day shift and night shift for monitoring. On 02/08/26, 02/09/26, 02/10/26, 02/11/26, 02/13/26, 02/14/26 on night shift, 02/16/26 on the day shift, 02/17/26 on night shift and 02/18/26 there was no evidence Resident #59's blood sugar was checked. On 02/14/26 on day shift, Resident #59's blood sugar was 269 and there was no evidence the physician or hospice services were notified or insulin was administered. On 02/16/26 on night shift, Resident #59's blood sugar was 156 and there was no evidence the physician or hospice services were notified or insulin was administered. Review of Resident #59's Medication Administration Record (MAR) started and discontinued on 02/08/26 revealed insulin lispro injection solution 100 units per ml, inject per sliding scale. If Resident #59's blood sugar was 151 to 200 administer one unit insulin, if the blood sugar was 201 to 250 administer two units, if the blood sugar was 251 to 300 administer 3 units, if the blood sugar was 301 to 350 administer four units, if the blood sugar was 351 to 400 administer five units of insulin, subcutaneously three times a day for diabetes mellitus. Review of Resident #59's progress notes dated 02/08/26 at 8:57 A.M. included Resident #59 was not safe to swallow and was unable to take oral medications.Review of Resident #59's progress notes dated 02/08/26 at 11:49 A.M. included hospice services assessed Resident #59 and a new order was given to discontinue all routine medications. Ativan and morphine were ordered to be administered as needed. Resident #59 was on the hospice service protocol EMC (even more care) due to status. Resident #59 was able to eat mashed potatoes and ice cream, pudding with his lunch and his status improved throughout the shift. Vital signs were obtained.Review of Resident #59's progress notes dated 02/08/26 at 7:54 P.M. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included Resident #59 did better with soft, thin food and food such as ice cream, applesauce, mashed potatoes and gravy were ordered. Resident #59 was able to swallow safely while alert.Review of Resident #59's care plan dated 02/09/26 included Resident #59 had a terminal prognosis with hospice services related to end of left diagnoses Alzheimer's Disease. Resident #59 would have an acceptable comfort level through the next review. Interventions included to administer medications as ordered and observe for effectiveness; collaborate with the palliative/hospice team to ensure Resident #59's emotional, spiritual, intellectual, physical and social needs were met and involve Resident #59, the family, clergy and other team members as needed; notify hospice services of changes in Resident #59's condition or updates.Review of Resident #59's progress notes dated 02/09/26 at 4:07 A.M. revealed due to stabilization of symptoms, continuous 24 hour care was discontinued. Resident #59 was to receive hospice visits three times a day per the hospice updated plan of care.Review of Resident #59's physician orders dated 02/10/26 revealed glucagon injection solution, inject 1 mg intramuscularly as needed for low blood sugar less than 60.Review of Resident #59's progress notes dated 02/11/26 at 3:29 P.M. included Resident #59 was awake, in good spirits and was sitting in his recliner. Resident #59 required two staff for transfers. Resident #59 attended bingo, Resident #59's family was visiting and hospice services were in the facility. Resident #59 continued on antibiotics for a urinary tract infection.Review of Resident #59's progress notes dated 02/11/26 at 4:18 P.M. included hospice services were in the facility and Resident #59 asked where the rest of his medications were beyond his antibiotics and as needed medications. The hospice staff stated she would talk to Resident #59's regular hospice nurse and no new orders were given at this time.Review of Resident #59's progress notes dated 02/11/26 at 4:18 P.M. through 02/17/26 at 4:55 P.M. did not reveal evidence Resident #59's medications were discussed with hospice services including blood sugar checks and insulin administration.Review of Resident #59's hospice Visit Patient Assessment Report dated 02/11/26 at 4:26 P.M. included Resident #59 was cheerful and reported that he loved [NAME] cups candy. Resident #59 inquired why he was not getting his scheduled medications. The hospice nurse explained to him that when he was admitted to hospice care the decision was made to discontinue routine medications and initiate comfort medications. Resident #59 verbalized understanding but wanted to be sure he had as needed medications in place for his bowels and mild pain and asked for something for anxiety. Resident #59 was administered lorazepam for anxiety.Review of Resident #59's hospice Visit Patient Assessment Report dated 02/13/26 at 8:47 A.M. included Hospice Nurse (HN) #601 visited Resident #59 for a daily watch care visit. Resident #59 was sitting in his recliner, was pleasant, disoriented times three with confusion. Resident #59 required meal prep and set up, was consuming a regular diet and his intake was 25 percent. Care was provided and Resident #59 was sitting in his recliner upon hospice departure, his call light was in reach and he had no signs and symptoms of acute distress. Resident #59 received lorazepam for intermittent anxiety.Interview on 02/19/26 at 8:01 A.M. of the Director of Nursing (DON) confirmed Resident #59 had not received insulin or had routine blood sugar checks from 02/08/26 through 02/19/26. The DON stated Resident #59 received hospice services and she would look into why Resident #59 was no longer receiving insulin. Observation on 02/19/26 at 9:44 A.M. of Resident #59 revealed he was sitting in his wheelchair and asked for help to use the bathroom. Resident #59 asked for the blinds to his windows be opened so he could see outside. Resident #59 was pleasant and answered questions appropriately.Interview on 02/19/26 at 9:44 A.M. of Licensed Practical Nurse (LPN) #238 revealed Resident #59 was back to himself now and was eating and acting like he used to act. LPN #238 stated Resident #59's pacemaker battery died, he needed to have it replaced about two weeks ago and he was much better now. LPN #238 stated Resident #59's decline was absolutely related to his pacemaker not working. LPN #238 indicated Resident #59 was put on hospice because we thought he was dying, and he was not receiving any medications or having blood sugars checked because he was receiving hospice services. LPN #238 stated she was confused why Resident #59's blood sugar checks were discontinued. Interview on 02/19/26 at 11:05 A.M. of Resident #59's Power (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Attorney (POA) #600 revealed Resident #59's catheter was put in wrong and he had to go to the hospital on [DATE]. POA #600 stated Resident #59 had to be transported to the hospital on [DATE] because he was filling up with fluid from his CHF. POA #600 indicated Resident #59 was out of it, restless, delusional and in bad shape when he was at the hospital and the physician recommended hospice services. POA #600 stated Resident #59 came back to the facility from the hospital on [DATE] and when he was in the hospital, they found out his pacemaker was not working and put a new one in. POA #600 stated after Resident #59's pacemaker battery was replaced he was improving. POA #600 stated she realized that Resident #59's blood sugars were not being checked, she was concerned and told an aide she was concerned, and she was not sure what happened after that. POA #600 could not remember which aide she told. POA #600 stated she was told Resident #59 was going to receive comfort care, but she did not realize that meant he was not going to be given any of his medications including insulin and heart medications.Interview on 02/19/26 at 9:53 A.M. of Nurse Practitioner (NP) #300 revealed Resident #59 was really out of it and unresponsive for awhile when he came back from the hospital and that was why he was put on hospice services. NP #300 stated he was doing better now, not out of the woods, but finger sticks should be started to check his blood sugar.Interview on 02/19/26 at 11:25 A.M. of LPN #236 revealed Resident #59 was on hospice and was taken off his medications including blood sugar checks and insulin. LPN #236 stated she did not know why Resident #59's blood sugars were not being checked, but that was through hospice and hospice would need to be asked that question.Interview on 02/19/26 at 12:00 P.M. of Assistant Clinical Director (ACD) #603 and Team Leader (TL) #604 of hospice services revealed they were not familiar with Resident #59 and Hospice Nurse (HN) #601 was the case manager would have more information. ACD #603 stated Resident #59 was placed on the EMC protocol because he was showing signs of imminent passing. ACD #603 stated if Resident #59 showed improvement then insulin and blood sugar checks could be added back in.Interview on 02/19/26 at 4:12 P.M. of Certified Nursing Assistant (CNA) #263 revealed he was told Resident #59 was probably going to die, his breathing was very low but all of a sudden, about nine days ago, he started pressing his call light, talking more clearly and started feeling better. CNA #263 stated he was eating about 25 to 50 percent of his meals and drank a lot of pop including Pepsi. Interview on 02/19/26 at 4:51 P.M. of Hospice Nurse (HN) #601 revealed Resident #59 was admitted to hospice services on 02/08/26 and he was showing signs and symptoms of end of life, was unresponsive and the EMC program was initiated. HN #601 stated Resident #59 started bouncing back a little bit and she saw improvement on 02/09/26. Resident #59 started talking and drinking fluids and his visits were decreased to three times a day. Resident #59 was then placed on routine visits because he was eating, drinking, talking, going to bingo and was back at his baseline. HN #601 indicated as far as Resident #59's insulin was concerned he was readmitted from the hospital and was not prescribed insulin. HN #601 stated the hospital discontinued Resident #59's medications and when the hospice service received his med list there was no insulin to be administered per sliding scale on it and we did not know he was on insulin. (Note: Resident #59's discharge instructions from the hospital included insulin lispro 100 units per ml, to be administered per sliding scale, three times a day). HN #601 stated she would notify the physician and have Resident #59's insulin administration per sliding scale restarted. Interview on 02/23/26 at 8:47 A.M. of the DON revealed when Resident #59 was placed on hospice services, hospice assessed him and made changes concerning his medications and other things. The DON stated after Resident #59 was placed on hospice services the facility physicians took a back seat and the hospice nurses were in contact with their medical director. The DON stated the facility would talk to the hospice nurse if it was felt a resident needed medications. Resident #59 was waxing and waning the first couple days he was on hospice services then he started improving to how he is now. The DON stated Resident #59 should have been reevaluated by the hospice nurse when he started doing better and she thought he should have been put back on his heart meds and insulin. The DON confirmed there should have been better communication between the facility and hospice services. Review of the facility policy titled (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice revised 10/26/2023 included when a resident chose to receive hospice care and services, the facility would coordinate and provide care in cooperation with the hospice staff in order to promote the resident's highest practicable physical, mental and psychosocial well-being. The plan of care would include directives for managing pain and other uncomfortable symptoms and would be revised and updated as necessary. The facility would immediately contact and communicate with the hospice staff, attending physician/practitioner and the family resident representative regarding any significant changes in the resident's status, clinical complications or emergent situations. This deficiency represents non-compliance investigated under Complaint Number 2647655.