Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365720 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/05/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Arbors at Stow | | STREET ADDRESS, CITY, STATE, ZIP CODE 2910 L'Ermitage Pl Stow, OH 44224 | |

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) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on record review, review of a self-reported incident (SRI), facility investigation, review of an employee personnel file, review of a police report, facility policy review and interview, the facility failed to timely report an allegation of staff to resident abuse. This affected one resident (#92) of three residents reviewed for abuse. The facility census was 127 residents.<br><br>Findings include:<br><br>Review of Resident #92's medical record revealed an admitted [DATE] and diagnoses including unspecified severe protein-calorie malnutrition, dementia without behavioral disturbance, major depressive disorder, history of COVID-19, dysphagia, cognitive communication deficit, and insomnia. Resident #92 had a guardian.<br><br>Review of a quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #92 was cognitively impaired and had inattention and disorganized thinking. Resident #92 wandered but did not reject care. Resident #92 required partial to moderate assistance with bathing, was independent with chair to bed transfers, independent with toilet transfers and was independent with ambulation.<br><br>Review of an SRI dated 03/17/24 timed 8:53 P.M. revealed an allegation of physical abuse involving staff and Resident #92. State tested Nursing Assistant (STNA) #202 alleged on 03/17/24 at 7:30 P.M. STNA #203 was assisting and holding Resident #92 by the biceps and seemed frustrated. Other witnesses stated nothing of concern on the unit and STNA #203 stated she held residents by the upper arm/bicep and held the hand of Resident #92 while guiding her to her room as a normal practice. Return demonstration to the Administrator and the Director of Nursing (DON) showed this was an acceptable approach. In addition to suspending STNA #203 while investigating the allegation, all residents on the C-pod had a physical assessment completed, the police were notified and Resident #92's responsible party and physician was notified. The facility educated staff on abuse as part of their investigation and determined the allegation of abuse to be unsubstantiated.<br><br>(continued on next page) |

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

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

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a witness statement for STNA #202 completed by the Administrator on 03/17/24 at 8:40 P.M. revealed identified the of the incident as 03/17/24 at (question mark), after dinner and before 8:00 P.M. and revealed the following information: Alleges that STNA #203 was holding residents by their biceps and pulling them and STNA #203 seemed frustrated when caring for the residents. When asked if she thought this appeared to be abuse, she stated 'I don't know, she seems frustrated.'<br><br>Review of a witness statement for STNA #203 completed by the Administrator on 03/20/24 indicated the incident occurred on 03/17/24 after dinner and before 8:00 P.M. and revealed the following information: She noticed Resident #92 becoming sleepy and escorted her back to her room. She dressed Resident #92 for bed and then went to lunch. Her return demonstration in front of the DON and the Administrator revealed she did have resident by the bicep and her other hand was in the hand of Resident #92 as she guided her to her room. DON confirmed this approach was appropriate.<br><br>Review of a witness statement for Licensed Practical Nurse (LPN) #210 completed by the Administrator on 03/17/24 at 9:00 P.M. revealed the following information: LPN #210 says she witnessed only good care during her shift. She has no issues with STNAs on the unit including STNA #203.<br><br>Review of a witness statement for Registered Nurse (RN) #209 completed by the Administrator on 03/19/24 for an incident on 03/17/24 revealed the following information: RN #209 was at the nurses' station at 7:00 P. M. on C-pod and stated all aides were working diligently and appropriately.<br><br>Review of a police report dated 03/18/24 revealed the Administrator wanted to report an allegation of possible elder abuse brought to her by one of the employees and stated STNA #202 reported STNA #203 was holding clients by the biceps and pulling them around during the shift. Only one client was named, Resident #92. The Administrator stated they take all allegations seriously regardless of how minor they appear to be due to the way the policy is written. STNA #203 was suspended per policy until their investigation was completed. The Administrator advised there appears to be no evidence to substantiate the allegations as of yet and the only concern as of now is STNA #202 waited two hours to report the incident if she felt abuse was taking place.<br><br>Interview was attempted on 04/05/24 at 9:12 A.M. with Resident #92. Resident #92 stated things were alright and she was treated okay. Resident #92 was noted to be pleasantly confused and had cognitive impairment.<br><br>Interview on 04/05/24 at 10:32 A.M. with STNA #202 revealed on 03/17/24 after dinner, approximately from 6:30 P.M. to 7:00 P.M. she saw STNA #203 have Resident #92 by her bicep coming out of the bathroom half pushing and half pulling her down to her room. STNA #202 stated STNA #203 then worked with one or two other residents and her own shift ended at 8:00 P.M. STNA #202 indicated she called the Administrator on her way home on 03/17/24 at 8:30 P.M. to let her know what she observed between STNA #203 and Resident #92. STNA #202 stated she was told you were supposed to call the Administrator immediately if you witnessed staff treating residents inappropriately. When asked how much time elapsed from the incident to when she called the Administrator to report the allegation, STNA #202 stated it was approximately 1.5 hours.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 04/05/24 at 11:04 A.M. with STNA #203 revealed on 03/17/24, from 7:30 P.M. to 8:00 P.M. she recalled getting Resident #92 ready for bed. Resident #92 had been sitting in a chair and she held her hand and had another hand on her forearm and guided her to her room. STNA #203 stated Resident #92 did not resist or pull. Once in the room, Resident #92 went to sleep. STNA #203 stated she went to lunch and when she got back from lunch around 9:00 P.M. she was told by a staff member (name not given) she had to clock out and go home. STNA #203 verified she was suspended during the course of the investigation and was allowed to come back once it was determined the allegation was unsubstantiated.<br><br>Interview on 04/05/24 at 12:40 P.M. with the Administrator and the DON revealed the Administrator received a call on 03/17/24 at 8:40 P.M. from STNA #202 who reported she saw STNA #203 pulling Resident #92 by the bicep. STNA #202 could not state when this happened but said it was after dinner but before she left, so sometime between 6:30 P.M. and 8:00 P.M. The Administrator stated she educated STNA #202 at this time all allegations of suspected or actual abuse were to be reported to her immediately and explained the facility expectation regarding abuse reporting started during orientation where each staff member was provided with the Administrator's cell phone number to facilitate timely reporting. The Administrator verified STNA #202 did not report the allegation of physical abuse timely, so STNA #203 was not removed from the facility in a timely manner.<br><br>Review of STNA #202's personnel file revealed a date of hire of 07/19/23 and abuse training as well as appropriate background checks were noted. A discharge warning document dated 03/21/24 was in the file due to the delayed reporting of the allegation of abuse.<br><br>Review of the facility policy, Abuse, Neglect and Exploitation, revised 01/10/24 revealed the facility would have written procedures that included reporting alleged violations to the Administrator, State Agency, and to all other required agencies (e.g. law enforcement when applicable) within specified time frames as required by state and federal regulations, immediately but not later than two hours after the allegation is made if the events that cause the allegation involve abuse. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse during and after the investigation by responding immediately to protect the alleged victim and the integrity of the investigation.<br><br>The deficient practice was corrected on 03/18/24 when the facility implemented the following corrective actions:<br><br>On 03/17/24 at 8:40 P.M. STNA #202 was suspended.<br><br>On 03/17/24 at 8:53 P.M. STNA #203 was suspended and removed from the facility.<br><br>On 03/17/24 at 9:00 P.M. the Nurse Practitioner was notified of the allegation.<br><br>On 03/17/24 at 9:20 P.M. Resident #92's guardian was notified of the allegation.<br><br>On 03/17/24, LPN #210 completed a skin assessment on Resident #92 with no discolorations or new areas noted.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/18/24 at 10:26 A.M. an ON-SHIFT message was sent to all nursing staff regarding the immediate reporting of suspected abuse to the Administrator and the immediate removal of an alleged perpetrator.<br><br>On 03/18/24, the police were notified of the allegation of physical abuse.<br><br>On 03/18/24, Licensed Social Worker (LSW) #208 interviewed all residents on C-pod regarding mistreatment with no negative findings.<br><br>From 03/18/24 to 03/21/24, Resident #92 was monitored for pain and bruising with no new findings.<br><br>On 03/18/24, the facility determined as STNA #203 worked on B-pod, C-pod and E-pod that those residents also had the potential to be affected. All residents on these units had skin assessments completed by unit nurses and LSW #208 also interviewed these residents regarding mistreatment with no negative findings.<br><br>On 03/18/24, the facility held an ad hoc quality assurance performance improvement (QAPI) meeting with the Medical Director in attendance.<br><br>On 03/18/24, all staff were educated on the facility abuse policy including immediate reporting and removal of alleged perpetrators as well as removing the abuse and stopping abuse.<br><br>Starting on 03/18/24, the Administrator/designee would interview five staff per week for four weeks on abuse reporting and removal of alleged perpetrator.<br><br>Starting on 03/18/24, the DON/designee would interview five staff daily Monday through Friday on abuse reporting and removal of alleged perpetrator across various shifts for four weeks. Audits will continue as determined by the QAPI committee.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00152319. |