STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, review of a facility self-reported incident (SRI), facility policy review, and interview the facility failed to ensure a resident was free from an incident of resident to resident abuse. This affected one resident (#113) of three residents reviewed for abuse. The facility census was 131. Findings include: Record review revealed Resident #113 was admitted to the facility on [DATE] with diagnoses included Wernicke's encephalopathy, receptive language disorder, anxiety disorder, anemia, insomnia, dementia, neuropathy, peripheral vascular disease, psychosis, schizoaffective disorder. Review of Minimum Data Set (MDS) 3.0 quarterly assessment revealed Resident #113 had severe cognitive impairment, delusional behaviors were displayed and rejection of care. Resident #113 needed assistance to eat but was independent for oral hygiene. Resident #113 was independent to roll left and right in bed, sit on the side of the bed and lie back in bed. Resident #113 was independent to walk ten feet. Review of a plan of care dated 05/20/24 revealed Resident #113 had behaviors related to dementia and pushed other residents. Interventions included a stop sign was placed on the resident's door to deter wandering residents from entering his room. Administration of medication as ordered. Approach resident in a calm manner to avoid frustration and behavior escalation. Attempt to redirect. Keep resident safe during episodes of behaviors. Offer psychiatrist services. Review of a nurse's note dated 10/11/24 at 5:34 P.M. revealed Resident #113 attempted to intervene with co-resident (Resident #133) being aggressive toward staff. Co-resident hit Resident #113 with his hand causing bleeding and a laceration to Resident #113 nose due to impact from co-resident. Laceration was cleansed with normal saline, and Tylenol was provided. Review of a Skin assessment dated [DATE] revealed Resident #113 had a left side nose laceration to the left side of the nose, area was cleaned. Record review revealed Resident #133 was admitted to the facility on [DATE] and discharged on [DATE]. Medical diagnoses included traumatic brain injury, epilepsy, altered mental status, impulse disorder, delusional, depression and heterophobia. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of MDS 3.0 quarterly assessment dated [DATE] revealed Resident #133 had severe cognitive impairment and delusions were indicated. Resident #133 displayed verbal behaviors towards others and rejected care. Supervision was needed for bed mobility and transfers. Supervision was needed for toilet transfers. Review of a plan of care care updated 08/30/24 revealed Resident #133 had behaviors related to traumatic brain injury with a history of aggressive behaviors and assault. Assault to other residents and refused medications. Interventions included educated resident with risk and benefits of medication. Stop sign to room to deter wandering residents from entering room. Administer medication as ordered. Approach resident in a clam manner. Communicate care to resident before starting task. Re-approach later. Keep resident safe during episodes of behavior and attempt to redirect. Observe and document episodes, notify physician when behaviors persist or will not de-escalate. Observe and report any change in mental status caused by situational stressors. Offer psychiatric services. Offer choices. Camouflage phone at nurses station. Review of psychiatry progress note dated 10/11/24 signed at 10:56 A.M. revealed Resident #133 was visited for a chronic psych medication visit. Resident #133 reported skipping doses of Tegretol. Sleep was poor. Resident #133 expressed frustration over current situation, comparing it to being in jail indicating this caused him anxiety. Resident #133 refused to take medication for sleep, anxiety or depression. Resident #133's mood was irritable and frustrated with a focus on a perceived lack of control of current situation. Assessment plan was to have Resident #133 adhere to medication regime, monitor impulse control behaviors and engage in therapeutic activities and strategies to manage impulsive behaviors. Staff was made aware of plan of care, monitor for medication effectiveness and adverse reaction. Review of nurse's note dated 10/11/24 at 5:46 P.M. revealed at 4:00 P.M. Resident #133 pulled the nurse's station phone from the station and yelled and called staff names. A co-resident (Resident #113) attempted to calm Resident #133. Resident #133 hit co-resident in the face. Call was placed to 911. Resident #133 was sent to a local hospital for evaluation. Resident #133 was not struck by co-resident. Review of facility Self-Reported Incident (SRI) tracking number 252891 dated 10/11/24 revealed the facility reported an incident of physical abuse involving Resident #113. The SRI revealed a male resident (Resident #133) swung at another male resident (Resident #113) causing a scratch on the nose that bled. Resident #133 was transferred to the hospital due to the incident. As a result of the facility investigation, review of the SRI revealed the facility substantiated the incident of physical abuse. Interview on 10/23/24 at 10:00 A.M. with the Interim Corporate Director of Nursing (DON) revealed Resident #133 had violent episodes and was transferred to the hospital on 10/11/24 following an incident of physical abuse against Resident #113. Interview on 10/23/24 at 1:17 P.M. with Social Worker # 417 revealed Resident #133 was sent to the hospital after a fight with another resident. Resident #133 was upset during the day and stated other residents were fearful of Resident #133. Resident #133 had a history of yelling and pounding on doors. Resident #133's cell phone had stopped working therefore he would use the portable phone. Resident #133 was frustrated while the portable phone was charging behind the nurse's desk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 2:45 P.M. Licensed Practical Nurse (LPN) #306 revealed Resident #133 was known to be combative if frustrated. Interview on 10/23/24 at 2:50 P.M. with Stated tested Nursing Assistant (STNA) #357 revealed Resident #133 was aggressive with other residents and other residents were afraid of Resident #133. STNA #357 witnessed the incident of physical abuse involving Resident #113 and stated Resident #113 approached Resident #133 to calm him but Resident #133 was out of control that day and hit Resident #113. Interview on 10/24/24 at 12:13 P.M. with Unit Manager LPN #310 revealed Resident #133 was known to be aggressive and unpredictable. Interview on 10/24/24 at 12:15 P.M. with Unit Manager #309 revealed Resident #133 often yelled to use the phone daily and had been aggressive during the day before the incident with Resident #113. The unit manager revealed Resident #113 was not an aggressive resident. An attempt to interview Resident #113 on 10/23/24 at 2:24 P.M. was unsuccessful as the resident exhibited cognitive impairment. Review of facility policy titled Abuse , Neglect and Exploitation (dated 07/28/24), revealed abuse was defined as the willful infliction of injury resulting in physical harm. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00158393.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, policy review, and interview the facility failed to provide timely discharge notice as required related to a resident's transfer and discharge. This affected one resident (#133) of three residents reviewed for transfer/discharge. The facility census was 131. Findings include: Record review revealed Resident #133 was initially admitted to the facility on [DATE]. Medical diagnoses included traumatic brain injury, epilepsy, altered mental status, impulse control disorder, depression, insomnia, cocaine abuse, mood disorder, restlessness and agitation. Review of a nurse's note dated 10/11/24 at 5:46 P.M. revealed at 4:00 P.M. Resident #133 was at the nurse's station. Resident #133 was yelling and calling staff names when a co-resident tried to calm Resident #133 down. Resident #133 then hit the co-resident in the face. Call was placed to 911. Resident #133 was sent to the hospital for evaluation. Review of physician's orders dated 10/11/24 revealed a verbal order was given to send Resident #133 to emergency room for evaluation and treatment one time only for aggressive behaviors for one day. Review of Social Service Transfer Log dated October 2024 revealed Resident #133's transfer date was 10/11/24, return was expected, and an emergency transfer was needed for psychiatric health. Review of facility document titled Transfer Notice (Resident Expected Return) transfer (dated 10/11/24) revealed a signed Certified Mail Receipt was attached and Resident #133's name was signed. Review of Discharge Return Anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the assessment was in progress and Resident #133 had an unplanned discharge on 10/11/24 to an inpatient psychiatric facility. discharge date was 10/11/24. Discharge status was short term general hospital. The assessment reference date was 10/11/24 with no end date. No active planning occurred for the resident to return to the community. No referral to Local Contact Agency (referral was not wanted). Leave days for Medicaid (bed hold days) end was 10/14/24. Review of the electronic medical record dated 10/14/24 revealed Resident #133 was discharged , and billing was stopped Review of a nurse's note dated 10/14/24 at 8:00 A.M. revealed Resident #133's guardian was notified on transfer to the hospital. Interview on 10/23/24 at 10:00 A.M. with the Interim Corporate Director of Nursing (DON) revealed Resident #133 was emergently transferred to the hospital after a violent episode. [NAME] was stopped on 10/14/24 because Resident #133 was considered discharged into the community from the hospital. The facility did not send an Emergent Discharge Notification to Resident #133. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 1:53 P.M. with the corporate interim DON verified the physician gave an order to transfer Resident #133 to the hospital but not to discharge Resident #133 from the facility. Interview on 10/24/24 at 9:00 A.M. with Ombudsman #420, who oversees the facility, revealed the facility had not notified her regarding Resident #133 emergent transfer or emergent discharge from the facility. Ombudsman #420 stated she needed to be notified to assist Resident #133 with appeals. The Ombudsman stated she had since had contact with Resident #133's guardian. Interview with Ombudsman #420 revealed Resident #133 was now past his ten-day appeal timeframe. Interview on 10/24/24 at 11:58 A.M. with Social Worker #417 revealed Resident #133's transfer and discharge was not traditional but an emergent transfer and discharge. The social worker revealed she presented a monthly report of traditional transfers and discharges to the Ombudsman at the end of each month. The Social Worker stated the transfer for Resident #133 was an emergent transfer and emergent discharge, therefore the Ombudsman should be notified sooner. The Social Worker verified an email was not sent to the Ombudsman regarding Resident #133. Resident #133 was not in the facility at the time of the survey. Review of facility policy titled Involuntary Transfer and Discharge (dated 4/12/18) revealed uniform guidelines related to involuntary transfer and discharge process was to ensure resident's rights were observed and proper notification to all interested. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00158393.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review and interview the facility failed to provide a resident and the resident's guardian of the resident's bed hold. This affected one resident (#133) of three residents reviewed for transfer/discharge. The facility census was 131. Findings include: Record review revealed Resident #133 was initially admitted to the facility on [DATE]. Medical diagnoses included traumatic brain injury, epilepsy, altered mental status, impulse control disorder, depression, insomnia, cocaine abuse, mood disorder, restlessness and agitation. Review of a nurse's note dated 10/11/24 at 5:46 P.M. revealed at 4:00 P.M. Resident #133 was at the nurse's station. Resident #133 was yelling and calling staff names when a co-resident tried to calm Resident #133 down. Resident #133 then hit the co-resident in the face. Call was placed to 911. Resident #133 was sent to the hospital for evaluation. Review of physician's orders dated 10/11/24 revealed a verbal order was given to send Resident #133 to the emergency room for evaluation and treatment one time only for aggressive behaviors for one day. Review of Social Service Transfer Log dated October 2024 revealed Resident #133's transfer date of 10/11/24, return was expected, and an emergency transfer was needed for psychiatric health. Review of a facility document titled Bed Hold Notification dated 10/11/24 revealed Resident #133 had used 17 leave days and there were 11 leave days remaining during the calendar year. No documentation was provided to Resident #133, or his representative at the time of discharge. Review of Discharge Return Anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the assessment was in progress and Resident #133 had an unplanned discharge on 10/11/24 to an inpatient psychiatric facility. discharge date was 10/11/24. Discharge status was short term general hospital. The assessment reference date was 10/11/24 with no end date. No active planning occurred for the resident to return to the community. No referral to Local Contact Agency (referral was not wanted). Leave days for Medicaid (bed hold days) end was 10/14/24. Review of the electronic medical record dated 10/14/24 revealed Resident #133 was discharged , and billing was stopped Interview on 10/23/24 at 10:00 A.M. with the Interim Corporate Director of Nursing (DON) verified the facility did not send a Bed Hold Notification to Resident #133 or his guardian. Interview on 10/23/24 at 1:17 P.M. with Social Worker #417 revealed a Bed Hold notice was prepared but not sent to the resident or guardian. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365720	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	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)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 1:53 P.M. with the corporate interim DON verified a Bed Hold Notice was not sent to the resident or guardian. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00158393.