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	11/21/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, record review, facility policy and procedure review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention and treatment program for Resident #44 to prevent the development of in-house pressure ulcers within 30 days of admission. Actual harm occurred on 11/01/24 when Resident #44, who was cognitively impaired, had a history of skin impairment, was at risk pressure ulcer development, and dependent upon staff for bed mobility, was assessed by facility staff to have deep tissue injury (DTI) (persistent non-blanchable deep red, maroon or purple discoloration due to underlying damage to soft tissue) pressure ulcers to the left heel and sacrum. The resident reported pain associated with the pressure ulcers. Prior to the development, there was no evidence comprehensive skin monitoring and/or effective interventions were in place to prevent the development of these ulcers. This affected one resident (#44) of three residents reviewed for pressure ulcers. Findings included: Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, dementia, right femur fracture, diabetes, transient ischemic attack, cerebral infarction, Alzheimer's dementia, hypothyroidism, major depressive disorder, post-traumatic stress disorder, adjustment disorder, heart failure, and pulmonary embolism. Review of the Admission Skin Assessment, dated 10/03/24, revealed Resident #44 had Moisture Associated Skin damage (MASD) to the coccyx and four stitches to the right upper leg. Review of the Admission Braden Scale (a tool used to assess a resident's risk for developing pressure ulcers), dated 10/03/24, revealed Resident #44 was assessed as being at moderate risk for pressure injuries. Review of the progress note dated 10/03/24 timed 1:56 P.M. revealed Resident #44 had two MASD areas noted to the coccyx with one being 1.0 centimeters (cm) and the other being 1.5 cm. Zinc oxide was applied as ordered by the nurse practitioner. Resident #44 had four steri-strips to the surgical incision on the right upper leg. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the admission physician's orders dated 10/03/24 revealed Resident #44 had orders for a pressure redistribution mattress to the bed (discontinued on 11/05/24), a redistribution cushion in the wheelchair, weekly skin assessments every Thursday, weight bearing as tolerated to the right hip, monitor the area to sacrum twice a day until healed (discontinued on 10/09/24), monitor MASD to the sacrum twice daily until healed (discontinued on 10/09/24), and apply zinc oxide ointment to the sacrum twice daily and as needed (discontinued on 10/18/24). Review of the plan of care, dated 10/03/24, with a revision date of 10/17/24, revealed Resident #44 was as risk for impaired skin integrity related to Alzheimer's disease, dementia, depression, diabetes, impaired cognition, incontinence of bladder and bowel and the need for assistance with activities of daily living. Interventions included apply protective barrier cream after each incontinent episode, assist the resident in turning and repositioning, complete Braden Scales, complete weekly skin assessment, encourage the resident to reposition self, and encourage and assist as needed to elevate the resident's heel off the mattress as tolerated (dated 10/18/24). Review of the Skin and Wound Evaluation, dated 10/09/24, revealed the MASD to the sacrum for Resident #44 was healed. Review of the Weekly Skin assessment dated [DATE] revealed Resident #44 had no new skin issues. However, the assessment included the resident had existing MASD to the sacrum as of this time even though the skin and wound evaluation dated 10/09/24 noted the area had healed. Review of the Admission Minimum Data Set assessment dated [DATE] revealed Resident #44 had moderately impaired cognition, required substantial (staff) assistance for turning side to side, was at risk for pressure injuries and did not have any unhealed pressure injury. The assessment included Resident #44 did have MASD. Review of the Weekly Skin assessment dated [DATE] revealed Resident #44 had no new skin issues, but had existing MASD to the sacrum. Review of the plan of care dated 10/18/24 revealed Resident #44 had impaired musculoskeletal status related to a fracture of the neck of the right femur. Interventions included to provide assistance with turning and repositioning as the resident would allow. Review of the physician's orders revealed Resident #44 had an order to apply house moisture barrier cream to the buttocks twice daily for prophylaxis, dated 10/18/24. Review of the Weekly Skin assessment dated [DATE] revealed Resident #44 had no new skin issues, but had existing MASD to the sacrum. Review of the October 2024 Nursing Assistant Task documentation revealed there was no documentation of Resident #44's heels being floated on 10/04/24 on the evening shift, on 10/06/24 on the evening shift, on 10/07/24 on the evening and night shifts, on 10/09/24 on the evening shift, on 10/11/24 on the day shift, on 10/14/24 on the evening shift and night shifts, and on 10/21/24 on the night shift. Review of the October 2024 Nursing Assistant Task documentation revealed there was no documentation of Resident #44 being turned or repositioned from 10/03/24 to 10/27/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the wound measurements and comprehensive wound assessments revealed there was no documentation from 10/10/24 to 11/01/24 of the MASD to the sacrum of Resident #44, though the nurses were documenting on the Weekly Skin Assessments the resident still had MASD to the sacrum. Review of a progress note dated 11/01/24 at 5:06 P.M. revealed Resident #44 had new skin areas. She had reddish discoloration to the left heel and sacrum. New orders were received for Skin prep (topical barrier), abdominal dressing (ABD), and Kerlix to the left heel daily, and to clean and apply a border foam dressing to the sacrum daily. Review of the Skin and Wound Evaluation, dated 11/01/24, revealed Resident #44 had an in-house acquired DTI to the left heel which measured 1.6 cm in length, by 2.1 cm in width, by an undetermined depth. The wound was described as an intact blister. A new order was received to cleanse the heel with normal saline, apply Skin prep, allow it to air dry, then pad and protect it with an ABD and Kerlix. The care plan was reviewed and updated for frequent turning and repositioning, and floating the heels. Review of the Skin and Wound Evaluation, dated 11/01/24, revealed Resident #44 had an in-house acquired DTI to the sacrum which measured 8.8 cm in length, by 6.1 cm in width, by no depth. The wound was described as maroon/purple in the center and the surrounding area was noted with erythema and non-blanchable. A new order was received to cleanse the sacrum with normal saline and pad and protect with border foam daily. Review of the plan of care dated 11/01/24 revealed Resident #44 had impaired skin integrity as evidenced by the deep tissue injury (DTI) to the sacrum and left heel. Interventions included administer treatments as ordered, barrier cream after incontinence episodes, staff assistance with turning and repositioning as needed, dietitian consultation, encourage good nutrition and hydration, encourage/assist as needed to elevate the residents heels off of the mattress as tolerated, hospice services, notify the nurse of any new skin impairment noted during care, an air mattress ordered on 11/05/24, and Prevalon (pressure relieving) boots as tolerated ordered on 11/04/24. Review of the physician's orders revealed Resident #44 had an order for Prevalon boots to be worn as tolerated, dated 11/04/24 and an order for an air mattress to her bed, dated 11/05/24. Review of the Skin and Wound Evaluation, dated 11/08/24, revealed Resident #44 had an in-house acquired DTI to the left heel which was measuring larger at 3.3 cm in length, by 3.7 cm in width, by an undetermined depth. The heel was described as soft/mushy/boggy and with an intact blister. The physician ordered staff to continue the treatments as ordered. Review of the Skin and Wound Evaluation, dated 11/08/24, revealed Resident #44 had an in-house acquired DTI to the sacrum which measured 0.8 cm in length, by 0.7 cm in width, by no depth. The staff described the wound as improving. Review of the Skin and Wound Evaluation, dated 11/13/24, revealed Resident #44 had an in-house acquired DTI to the left heel which measured 2.9 cm in length, by 3.6 cm in width, by an undetermined depth. The heel was described as an intact blister, it was less soft/boggy, and it was dark reddish-brown in color. The note indicated the wound was improving. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Skin and Wound Evaluation, dated 11/13/24, revealed Resident #44 had an in-house acquired DTI to the sacrum which measured 0.4 cm in length, by 0.3 cm in width, by no depth. The skin was noted as intact and normal in color. Observations of the pressure ulcers to Resident #44 on 11/19/24 at 8:45 A.M. with Registered Nurse (RN) #307 revealed the coccyx wound was a small open area the size of a pencil eraser with 100 percent (%) granulation tissue present and the would bed was pink. The left heel was a very large blister that covered the whole heel. The blister was still partially fluid filled and the wound was soft/boggy. The outer edge of the blister was dark purple in color and the blister was white/light pink in color. Resident #44 was wearing Prevalon boots and an air mattress was on the bed at the time of the observation. During interview on 11/19/24 at 8:45 A.M. with Resident #44, at the time of the wound observation, Resident #44 stated it (insinuating the wound) hurt her badly and she did not know why. On 11/19/24 at 11:15 A.M. an interview with RN #307 verified Resident #44's current pressure injuries were in-house acquired. On 11/19/24 at 2:27 P.M. an interview with the Director of Nursing (DON) confirmed both of Resident #44's pressure wounds were in-house acquired. During the interview, the DON stated she was not sure why the Prevalon boots were not ordered until 11/04/24 and the air mattress until 11/05/24 (after the ulcers were identified). The DON revealed the Prevalon boots had to be ordered because they were not kept in stock. On 11/19/24 at 3:12 P.M. a second interview with the DON revealed she was mistaken, staff had implemented the air mattress and Prevalon boots on 11/01/24 (the day the DTI ulcers were identified); the DON stated she did not know why the physician order was not written until days later. The DON confirmed the measurements showed a decline in the left heel wound from 11/01/24 to 11/08/24 however she did not believe the floor nurse assessed it properly on 11/08/24 when she noted the wound as stable. On 11/20/24 at 4:38 P.M. an interview with the Administrator confirmed the nurses were not measuring/assessing the affected areas to Resident #44's sacrum once the skin was intact. Staff continued to reflect the MASD to sacrum on the Weekly Skin assessments, but confirmed there were no measurements of the area documented (and staff had noted the MASD had healed on 10/09/24). On 11/20/24 at 4:50 P.M. an interview with the Administrator verified direct care/nursing assistant staff did not include written evidence of turning and repositioning as per the resident's plan of care until 10/27/24. Review of the facility policy titled, Pressure Injury Prevention Guidelines, dated 03/20/24, revealed the facility would prevent the formation of avoidable pressure injuries and promote healing of existing pressure injuries. It was the policy of the facility to implement evidence-based interventions for residents who were assessed as being at risk or for residents who had a pressure injury present. This deficiency represents non-compliance investigated under Complaint Number OH00159238.

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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** 35765 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of the medical record, review of the facility's investigation, interviews with facility staff, and review of the facility policy on elopement, the facility failed to ensure staff provided adequate supervision to prevent Resident #33 from leaving the facility unsupervised. This affected one resident (#33) of three residents reviewed for elopement/exit seeking behaviors. Findings included: Review of the medical record revealed Resident #33 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, cerebral infarction, atherosclerotic heart disease, peripheral vascular disease, alcohol abuse, insomnia, hypertension, osteoarthritis, vascular dementia, psychosis, major depressive disorder, and generalized anxiety disorder. Review of the physician's order, dated 03/06/24, revealed Resident #33 had an order to reside on the secure unit for safety, secondary to dementia. Review of the plan of care, dated 03/07/24, revealed Resident #33 was at risk for elopement related to a history of elopement at another facility and the resident would verbalize wanting to leave the facility. Interventions included to calmly redirect, divert the residents attention, distract the resident when wandering or when he was insistent on leaving facility by offering pleasant diversions, structure activities, food, conversations, television, and books, promptly check when the alarm system went off to ensure the resident was safe and remained in the facility, refer to a psychiatrist or psychologist as needed. The care plan was updated on 08/10/24 to include one on one supervision. Review of the of Elopement assessment, dated 05/19/24, revealed Resident #33 attempted to open the window in his room that went outside to the courtyard. Review of the progress note, dated 05/19/24 at 11:20 P.M., revealed Resident #33 had attempted to open the window in his room that went out into the courtyard. The resident was unhappy with his living situation. The attempted interventions were to block the window with a tray table, lower the window blinds, and the door to the room was to be left open. Review of the progress note, dated 06/03/24 at 1:15 P.M., revealed Resident #33 was watching the staff leave the unit to obtain the door code. The door code had to be changed. Review of the progress note, dated 07/24/24 at 4:32 P.M., revealed Resident #33 had exhibiting exit seeking behaviors, verbal aggression and he was resisting care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a signed handwritten witness statement from Certified Nursing Assistant (CNA) #303, dated 08/10/24 at 9:00 A.M., revealed she was doing rounds at around 7:00 A.M. when Resident #33 came out of his room for a glass of water. He was given a glass of water and he sat down beside her while she was charting. She went into the shower room to get supplies and clean up her mess and the breakfast meal trays came out around 7:45 A.M. Staff passed out the trays. Resident #33 did not come out for breakfast like he usually did, so the other nursing assistant took Resident #33 his tray and CNA #303 went into another room to feed a dependent resident. The other nursing assistant and the nurse stated Resident#33 was missing, so all three of staff began searching the rooms and bathrooms, then the rest of the building. She stated she left at around 8:30 A.M. to drive the perimeter to see if she could locate him. When she could not find him she was asked to go back into the building while the remaining staff continued to search for him. She noted that the resident had a history of exit seeking behaviors. Review of a signed handwritten witness statement from Licensed Practical Nurse (LPN) #301, dated 08/10/24 at 9:00 A.M., revealed at around 7:00 A.M., Resident #33 came to the nurse's station, asked for a cup of water which she gave him and he sat down in the common area. She went to another unit to pass morning medications and then she returned to unit Resident #33 was on. LPN #301 stated she began to pass medications and when she got to Resident #33's room around 8:15 A.M., she noticed he was not in his room. The nursing assistant had his breakfast and stated she did not know were Resident #33 was. They immediately began searching the entire unit and could not find Resident #33. They began to search the hallways, lobby areas, and the perimeter. She stated she notified the Administrator and Director of Nursing and then called 911 to notify the police. She stated staff members then began driving to surrounding areas looking for Resident #33 and remaining staff continued to search the building. Review of a signed handwritten witness statement from CNA #302, dated 08/10/24 at 9:00 A.M., revealed around 7:00 A.M. Resident #33 came out to the nurse's station asking for a glass of water and came over and sat down by her. CNA #303 called CNA #302 into another room to help with another resident, then the breakfast trays came out and they started passing the trays. LPN #301 went to give Resident #33 his medications and realized he was not in his room. The staff searched the unit, lobby, and hallways. Management was notified and some of the staff drove around looking for him. Review of a signed handwritten witness statement from LPN #300, dated 08/10/24 with no time documented, revealed she was notified by the floor nurse that the staff could not locate Resident #33 after checking the pods, hallways, and facility perimeter. A Code Yellow (the facility notification system regarding a missing person) was called immediately and she took the initiative to drive around the community searching for him. The resident was located by a Country Club on [NAME] Road. She asked the resident if he needed a ride and the resident stated no. She proceeded to park her vehicle and attempted to converse with the resident, when he crossed the street and ran into the woods. She contacted 911 to inform the dispatcher that Resident #33 was found and she was following him into the woods and she needed assistance. She continued to follow the resident into the woods when she received a call from 911 stating she needed to move her vehicle immediately and to get out of the woods. She attempted to explain to the dispatcher that she had eyes on the resident and she was actively following him. The dispatcher insisted she needed to come out of the woods and move her vehicle immediately. She proceeded to walk back up the main road and move her vehicle. She asked the police officer what was on the other side of the woods and the police officer told her a lake. LPN #300 got in her vehicle and continued to search for the resident in the lake area until the unit manager called her and stated the police had the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the late entry progress note, dated 08/10/24 at 10:00 A.M., revealed the police department called the facility and had Resident #33 in custody and they were sending him to the hospital for an evaluation. Review of the late entry progress note, dated 08/10/24 at 11:56 A.M., revealed at around 8:30 A.M. the staff noticed Resident #33 was missing. The Director of Nursing and the weekend supervisor were notified at around 8:40 A.M. after staff searched for the resident. The police were contacted at around 8:45 A.M. and the residents guardian was notified around 10:00 A.M., then the physician was notified. Review of the progress note, dated 08/10/24 at 2:51 P.M., revealed upon entering Resident #33's room to administer morning medications, it was noted that the resident was not in the room. The nurse immediately checked the bathroom, common areas, all other rooms and bathrooms on the unit. The nursing assistants also helped check the rooms. The nurse checked the lobby, hallways, and bathrooms outside the unit. The supervisor was notified of the elopement and a Code Yellow was called over the facility intercom. The perimeter was checked by the staff and the staff checked the surrounding streets via car. 911 was phoned to notify the police of the resident's elopement. Review of the progress note, dated 08/10/24 at 4:39 P.M., revealed Resident #33 returned to the facility from the hospital via a transport service. He was very agitated and was not allowing staff to help him. Skin checks were completed and he had a skin tear to the right forearm. The area was cleaned with normal saline, triple antibiotic was applied and a border gauze dressing was applied. The nurse practitioner was notified of his return and of his laboratory results from the hospital. He was oriented to his room and call light and one on one supervision was put into place. He had no complaints of pain or discomfort. Resident #33 stated he did not have a plan as to where he wanted to go, he just wanted to leave the facility. Review of the typed statement from Resident #33, dated 08/12/24 at 2:50 P.M., revealed he had left the facility to stop his friend from getting rid of his boat that he has had since January. The resident indicated the boat was located near portage lakes and he was going to walk there. He stated he received a skin tear to his right arm from walking in the woods, but he was fine because he was an avid deer [NAME]. He indicated he typed in the code and would not indicate how he got the code. He stated after he exited the pod, he exited out the front doors and started walking. He stated he never informed the staff of his desire to leave prior to his exit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the police report, dated 08/10/24 at 8:43 P.M., revealed LPN #301 had called and reported a missing person (Resident #33). The shift was dispatched to the area of the facility address for a dementia resident who had walked away from the facility. The caller stated Resident #33 had left the facility at 7:30 A. M., but the police department was not notified until 8:43 A.M. While in route to the area, the caller stated they were with a male at the golf course, and then they hung up on the call taker for the police department. The caller stated she was at the Country Club and the male was in the woods. The police arrived on scene and was unable to locate any of the parties. The initial caller was told to return to her car and they obtained more information. The nurse following him stated he walked into the woods behind the insurance company and was headed southbound. Due to multiple staff members walking the woods, the canine unit would not be able to be utilized. All Officers began checking the lake area for Resident #33. After an extensive foot search of the area, a drone team was called for further assistance in locating Resident #33. A short time later the drone team arrived and began an aerial search of the area, just south of the property of the insurance company. Resident #33 was found by the lake and had a laceration to his hand. The facility was notified and Resident #33 was taken to the hospital for further evaluation. Review of the fire department report, dated 08/10/24 at 9:19 A.M., revealed they received a call from the police department for a [AGE] year-old male who walked away from his nursing home. Resident #33 stated he was sick of being there. His court appointed guardian asked for him to be taken to be evaluated. She stated he had a history of attempting to leave care facilities and refused to take his medications. He was alert and oriented, warm and dry and speaking in complete sentences. Review of the video surveillance timeline revealed on 08/10/24 at 6:56 A.M. Resident #33 was given a glass of water then another glass of water at 6:58 A.M. At 7:04 A.M. he returned the glass of water. At 7:14 A.M. he walked by the exit door. At 7:21 A.M. Resident #33 was fully dressed in an orange sweatshirt, black hoodie, dark jeans, and black tennis shoes, he was seen entering the code and walking off of the unit. Review of the facility investigation revealed on 08/10/24 at 8:30 A.M. the nurse went to give Resident #33 his medication and noticed he was missing, so a Code Yellow was called. The entire facility was searched by all staff. At 8:40 A.M., the Administrator was notified by the weekend supervisor that the resident was found by the Country Club, 911 was called for assistance, and the supervisor had eyes on the resident. At 8:50 A.M. the Administrator and Weekend Supervisor were on scene and the police advised them to get out of the woods so they did not mess up the residents scent. At 9:15 A.M. the cameras were reviewed. At 9:30 A.M. the police arrived at the facility. At 10:00 A.M. the resident was located by the police and transported to the hospital. At 10:05 A.M. the guardian was notified. Review of Google Maps revealed the Country Club was 3.7 miles from the facility via city roads. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #33 had severely impaired cognition, disorganized thinking, delusions, verbal behaviors, rejected care, and wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 10:55 A.M. an interview with LPN #301 revealed she was the nurse working the morning Resident #33 eloped. She stated she and the nursing assistants were in rooms with other residents when Resident #33 left. She stated the cameras showed him going into his room to get his jacket, then he came out, put in the door code, and left the unit. She stated she did not know how long he was gone, but the police found him and took him to the hospital. On 11/18/24 at 2:50 P.M. an interview with Maintenance Director #305 revealed he was changing the door codes all the time because Resident #33 kept figuring the codes out. He stated he normally just changed them once a month. He stated all the staff had the code and they were not to give the codes out to family members, but it did happen at times. He stated after Resident #33 got out of the building, he put the covers on the door code boxes. Review of the facility policy titled, Unsafe Wandering and Elopement Prevention, dated 01/10/22, revealed every effort would be made to prevent unsafe wandering and elopement episodes, while maintaining the least restrictive environment for residents who were at risk for elopement. Nursing personnel must report and investigate all reports of missing residents. The deficient practice was corrected on 08/12/24 when the facility implemented the following corrective actions: Facility staff completed a facility head count immediately on 08/10/2024 with all other residents accounted for. Facility staff completed a whole facility audit of windows to validate all security measures were in place on 08/10/2024. Security measures consisted of securing windows to ensure residents did not have the ability to access the courtyard from their bedroom windows. Maintenance Director #305 and the Administrator completed a whole facility audit of all doors to validate the alarm systems were in working order with no discrepancies identified, on 08/10/2024. Maintenance Director #305 and the Administrator changed the security codes on all doors on 08/10/2024. Maintenance Director #305 placed a cover over the B Unit keypad, to hinder the ability to view the code punches, on 08/10/2024. All staff were educated on the facility policy for elopement and missing residents, by 08/10/2024, by the nursing administration staff/Administrator. All staff were educated on using discretion when entering codes on secured doors and sharing security codes only with staff. The education was completed by the Administrator/nursing administration staff by 08/10/2024. All non-direct care staff were educated by the Staff Development Coordinator (SDC) #400 on not assisting residents off the units, by 08/12/2024. All nurses were educated by the SDC #400 regarding accuracy of risk assessments for elopement, when to complete the assessment, and care planning accuracy, by 08/12/24. (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	11/21/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All nurses were educated by the SDC #400 regarding documentation accuracy and indication of an incident time in the progress notes, if it was not documented when it occurred, by 08/12/24. All nurses were educated by 08/12/24 by the SDC #400 regarding: implementing timely interventions when a resident was displaying exit seeking behavior, revising the care plan, and notifying the DON/Administrator and Medical Director. The facility reviewed residents residing at the facility who were at risk for elopement, to validate that the elopement assessments and care plans were current and accurate. The review was completed by the Director of Nursing (DON)/Designee by 08/12/2024. The Facility Administrator/Designee would complete elopement drills two times a week for two weeks. Thereafter, facility would continue monthly elopement drills (one on each shift per quarter). The Facility Administrator/Designee would complete staff interviews three times weekly for four weeks to validate staff had not shared door security codes with non-staff and they could identify how to access the code with discretion. Immediate education would be completed if discrepancies were identified. The DON would review progress notes daily, Monday through Friday, for four weeks and any documentation of exit seeking behaviors would be reviewed to ensure care plan revision and intervention implementation. The DON would review Risk for Elopement assessments and Nursing quarterly assessments completed to ensure they were accurate, Monday through Friday, for four weeks. The DON would review progress notes to ensure incidents reflected accurate timing of events, Monday through Friday, for four weeks. Maintenance Director #305/Designee would change all security codes monthly and as needed, ongoing. The Quality Assessment and Process Improvement (QAPI) team met on 08/10/24 and 08/12/24 to discuss the Elopement Policy, discretion when utilizing the code to exit a unit, changing the unit codes, and review of the elopement binder to ensure current elopement assessments and care plans were appropriate. This deficiency represents non-compliance investigated under Complaint Number OH00159238.