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	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	2910 L'Ermitage Pl Stow, OH 44224

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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 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** Based on review of the medical record review, facility incident report review, interview with staff, and review of the facility's abuse policy the facility failed to provide adequate supervision to prevent physical abuse of a cognitively impaired resident (Resident #131) by another resident identified by the staff to have aggressive behaviors. This affected one resident (Resident #131) of 21 residents reviewed for abuse.Findings include:Review of the medical record revealed Resident #157 was admitted to the facility on [DATE] with diagnoses including hearing loss, cerebral ischemia, asthma , major depressive disorder, generalized anxiety disorder, and dementia.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #157 had severely impaired cognition. Resident #157 had delusions, physical and verbal behaviors, rejection of care, and wandering. Review of the plan of care dated 04/02/25 revealed Resident #157 had behaviors related to dementia as evident by exit seeking, physical aggression towards staff, resistant to care, verbally aggressive towards staff, wondering in other resident rooms, wandering through facility with no sense of direction, lower self on the floor, grabbing, kicking, hitting, pushing, cursing at others, anger towards others, screaming, disruptive sounds, wandering and co-resident rooms, repetitive motion, agitation, anxiety and restlessness, sad and tearful. Interventions included administer medication as ordered and observe for effectiveness and side effects, approach resident in a calm manner to avoid frustration and behavior escalation, communicate care to resident before starting task, if the resident resist with activities of daily living reassure the resident leave and then return later to try again, observe and document episodes of inappropriate behavior, notify the physician or nurse practitioner when behaviors persist or will not deescalate, observe and report any, provide positive feedback to the resident when behaviors or changes in mental status caused by situational stressors, observed behavior episodes and attempt to determine underlying cause, offer psychologist and psychiatric services as needed offer resident choices whenever possible, provide a calm safe environment when the residents frustrations escalate and allow time to voice feelings, provide a structured schedule for daily care when possible.Review of the medical record revealed Resident #131 was admitted to the facility on [DATE] with diagnoses including vascular dementia, dementia, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, chronic kidney disease, atherosclerotic heart disease, congestive heart failure, anxiety disorder, peripheral vascular disease, pain, hypertension, osteoarthritis, diverticulosis, cognitive communication deficit, and major depressive disorder. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #131 had severely impaired cognition.Review of the Incident Audit Report dated 08/23/25 at 2:15 P.M. revealed a nursing assistant called the nurse over and stated Resident #157 hit Resident #131 in the left side of her chest with her hand. The other resident was redirected immediately from Resident #131. The nurse assessed Resident #131 and there was no redness or bruising noted to the area, vital signs were blood pressure (B/P) 125/76, pulse (AP) 72, respirations (R) 16, oxygen level 97 percent (%) on room air (RA). The physician and family were notified. New order was implemented to monitor the area for pain or bruises for three days. Resident #131 stated it did hurt but she did not know why the other (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had hit her. Review of the Physical Aggression Form dated 08/23/26 at 2:15 P.M. revealed there was a section for witness statements. Certified Nursing Assistant #625 stated she was discarding trash and heard yelling, She looked out in the common area and seen Resident #157 hit Resident #131 in the chest, and she immediately stepped in to move Resident#157 away. Review of the Nurse's note dated 08/25/26 at 2:59 P.M. revealed Nurse Practitioner (NP) #652 was in the facility to see Resident #131 and order a two-view chest x-ray due to an increase in pain from resident-to-resident altercation a few days ago to rule out rib fractures. Review of the Chest X-ray report dated 08/25/25 revealed Resident #131 had no fractures however she did have left side opacites (haziness/whiter tissue).Review of the August 2025 Medication Administration Report (MAR) dated 08/25/25 at 10:25 A.M. revealed Resident #131 was administered Acetaminophen 1000 milligrams (mg) for left breast pain for a pain level six out of ten. There was no documentation of the medication being effective. Review of the Acute Visit Note from NP #652 dated 08/25/25 at 1:48 P.M. revealed the reason for the visit was due to a follow up for cellulitis and left breast pain secondary to trauma. Resident #131 was stuck by another resident on 08/23/25 on the left side of the chest and breast. She reports mild intermittent pain localized to the side of the left breast with no involvement of the chest. She denied shortness of breath. Physical examination revealed no bruising or visible injury to the left side of the chest or breast. Ordered a one-time dose of Tylenol 100 milligrams and monitor for any late onset signs of injury. Review of the Triage on call note dated 08/25/25 at 10:24 P.M. revealed the on-call Nurse Practitioner #653 was told by the staff, Licensed Practical Nurse #512, that Resident #131 had a chest x-ray for complaint of pain from a resident-to-resident altercation and the resident had discoloration to the left chest. Review of the August 2025 MAR dated 08/26/25 at 5:00 A.M. revealed Resident #131 was administered Acetaminophen 650 milligrams for complaint of nine out of 10 left breast pain. Review of the Administration note dated 08/26/25 at 6:07 P.M. revealed the Acetaminophen was effective with a follow up pain level of six out of ten. Review of the August 2025 MAR dated 08/26/25 at 7:37 P.M. revealed Resident #131 was administered acetaminophen 650 milligrams for complaint of three out of 10 left breast pain which was later documented as effective.Review of the Acute Visit note written by NP #652 dated 08/26/25 at 1:07 P.M. revealed the reason for the visit was Resident #131 was being evaluated for left side chest pain following a resident-to-resident altercation. Resident #131 sustained a contusion to the left front wall of the thorax following an alternation with another resident. Resulting in pain that was initially rated an eight out of 10 by nursing staff. She was administered 1,000 milligrams of Acetaminophen without relief. Due to her multiple allergies an advanced age further pain medication was not administered. Biofreeze was applied, which Resident #131 reported provided some relief. Review of the August 2025 MAR dated 08/27/25 at 12:11 P.M. revealed Resident #131 was administered Acetaminophen 650 milligrams for complaint of six out of 10 left breast pain which was later documented as effective. Review of the Nurse's note dated 08/27/25 at 2:19 P.M. revealed Resident #131 was anxious. The NP was notified an ordered to increase the Depakote to 125 milligrams to twice daily as well as Vistaril 25 milligrams every six hours as needed for 14 days for anxiety. The family was notified. There was no further documentation as to why the resident was anxious. Review of the August 2025 MAR dated 08/27/25 at 3:40 P.M. revealed Resident #131 was administered Vistaril 25 milligrams for anxiety. Review of the Acute Visit notes dated 08/28/25 at 2:29 P.M revealed over the weekend Resident #131 was struck on the left side of her chest by another resident and has since been experiencing mild pain in the area. The family was expressing concern which lead to the initiation of Prednisone by the on-call NP and additionally her Doxycycline was extended three more days and an order for Biofreeze was put into place until 09/02/25. Resident #131 was also started on Vistaril 25 milligrams every six hours as needed by psychiatric services for a two-week trial until 09/10/25 to address anxiety related symptoms. Review of the Nurse's note dated 08/30/25 at 9:09 P.M. revealed Resident #131 complained of left chest aching pain. Acetaminophen was given but was ineffective. Vital signs were B/P 155/68, AP 115, R 16, and oxygen lever 92 % on RA. The on-call service was called, and new (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders were received to discontinue the prednisone, apply a Lidoderm patch to the rib cage daily and to be taken off at night and on during the day for seven days, stated levofloxacin 750 milligrams every 48 hours chest pain for five doses. The family was to be notified by the on-call service. And second note dated the same indicated the resident received a new order for complete blood count and basic metabolic panel. Review of the Nurse's note dated 08/30/25 at 10:38 P.M. revealed Resident #131 received a new order for a chest x-ray and the family was aware. Review of the Chest X-ray report dated 08/31/25 revealed Resident #131 had no acute pulmonary disease. Review of the August 2025 MAR dated 08/31/25 at 7:53 A.M. revealed Resident #131 was administered Acetaminophen 650 milligrams for complaint of four out of 10 left breast pain which was later documented as effective.Review of the August 2025 MAR dated 08/31/25 at 9:12 A.M. revealed Resident #131 was administered Vistaril 25 milligrams for anxiety.Review of the August 2025 MAR dated 08/31/25 at 12:15 P.M. revealed Resident #131 was administered Acetaminophen 650 milligrams for complaint of nine out of 10 left breast pain which was documented as ineffective. Review of the Nurse's note dated 08/31/25 at 12:38 P.M. revealed Resident #131 was still complaining of pain in the left chest and the nurse reached out to the on-call service and received a new order for an immediate (STAT) 12 led Electrocardiogram (EKG) and troponin level (heart protein level), DuoNeb aerosols every six hours as needed for three days. The resident and daughter were aware of the new orders.Review of the Administration note dated 08/31/25 at 12:45 P.m. revealed the Acetaminophen was ineffective and the pain lever for Resident #131 was now a 10 out of 10. Review of the Nurse's note completed by Unit Manager #633 dated 08/31/25 at 1:58 P.M. revealed Resident #131 complained of chest pain this shift. Vital signs and assessment were completed by the floor nurse as charted, as needed Acetaminophen was administered, and a Lidocaine patch was in place per orders. The on-call service NP was notified and gave new orders for a STAT 12-lead EKG, Troponin level to be drawn, and DuoNeb treatments every six hours as needed for three days. The EKG service was contacted and reported the EKG could not be performed STAT, and they would contact the facility with an estimated time of arrival, STAT chest X-ray had been completed the night before with negative results. The on-call NP was aware. The resident's sister was at bedside and induced panic by yelling and repeatedly stating the resident could not breathe and was still in pain. This behavior increased resident distress, and resident demonstrated labored breathing patterns and episodes of emesis. The nurse attempted to reassure the resident and redirect to help calm the situation. Vital signs were oxygen level 98% on RA, AP 84, R 18, Temperature 97.7, and BP 98/54. The on-call NP was updated, Acetaminophen was given, and Nitroglycerin 0.4 milligrams sublingual was administered for one dose. The resident's daughter got to the facility and contacted the on-call service herself and demanded her mother be transferred to the emergency room (ER) for further evaluation and treatment. Emergency Medical Services (EMS) were contacted per the on-call orders. EMS conducted an EKG at bedside, which showed no acute abnormalities. Resident #131 was transferred to the ER for further evaluation. Report called to ER by the nurse.Review of the emergency room report dated 08/31/25 revealed Resident #131 was presented to the ER for evaluation of chest and abdominal pain. The family indicated the resident was punched by another resident at the facility about a week ago and since had been experiencing chest wall tenderness on the left side and had recently been treated for pneumonia. CT scan of abdomen and pelvis indicated of evidence of pulmonary embolism, no acute rib fractures however there were some chronic right sided rib fractures, there was dilation of pancreatic duct, mild hydronephrosis related to greatly distended bladder, dissection of the abdominal aorta. The plan was for no acute interventions for the aortic dissection just continue with BP medications. On 03/18/26 at 9:38 A.M. an interview with the Director of Nursing (DON) revealed the facility did not complete a Self-Reported Incident between Resident #131 and #157 because Resident #131 was not injured.On 03/19/26 at 9:40. A.M. an interview with Family Member #661 revealed Resident #131 was punched in the chest by another resident. She stated her mother was complaining of chest pain, so the facility did a chest x-ray which showed pneumonia but not broken ribs. She stated her aunt was visiting her (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mother and her mother was having trouble breathing and complaining of chest pain and the facility would not send her out to the hospital. She stated she went to the facility and had to call the on-call service herself to have her sent out to the Emergency room. She stated mother had a tear in her aorta and the emergency room physician asked her if her mother was in a car accident because the type of injury she had was from trauma however they could not prove it was from being punched in the chest. She stated her mother had a slight discoloration to her chest from being hit. She stated the hospital took pictures.On 03/23/26 at 1:10 P.M. an interview with NP #652 revealed she did not have access to her notes because she did not work for the on-call service any longer but would answer question the best she could. She stated she remembered Resident #131 had been hit by another resident . She stated the resident has been complaining of chest discomfort and muscular skeletal pain, so she had diagnosed her with a chest contusion even though she did not have any visible bruises at that time. She stated it was appropriate to diagnoses her as such because she had a blunt force trauma to the area. She stated the resident had dementia, so it was difficult to get appropriate information from her but if she remembered correctly the resident daughter was highly involved with her care. She stated she had ordered two separate chest x-rays and started her on an antibiotic and the facility NP had extended that antibiotic. She stated she only worked at the facility Monday through Friday, so she was not called during the weekend. She stated she only physically seen the resident right after she was hit on that Monday (08/25/25).Review of the facility policy, Abuse, Neglect and Exploitation, revised 01/10/24, revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent and prevent abuse, neglect, exploitation and misappropriation of resident property. Physical Abuse included but was not limited to hitting, slapping, punching, biting and kicking, The facility will have written procedures to assist staff in identifying the different types of abuse; possible indicators of abuse include but are not limited to physical abuse of a resident observed. The facility will have written procedures that include reporting of alleged violations to the state agency within specified timeframes 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 or result in serious bodily injury.This deficiency represents non compliance investigated under Complaint Number 1295325, and 2611622.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to implement their abuse policy to timely report allegations of abuse. This affected five residents (#8, #77, #131, #155 and #157) out of 21 residents reviewed for abuse. Facility census was 131.Findings include:1. Review of Resident #8's closed medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, dementia with mood disturbance, diabetes, bipolar disorder, anxiety, depression and obesity. Resident #8 expired in the facility on [DATE] on hospice services. Review of Resident #8's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 had a memory problem, knew the location of his own room, displayed disorganized thinking and inattention, wandered one to three days in the look-back period, showed verbal and other behavioral symptoms one to three days in the look-back period and displayed physical behavioral symptoms four to six days in the look-back period. Review of Resident #8's plan of care initiated [DATE] and revised [DATE] revealed Resident #8 had behaviors related to dementia as evidenced by verbally aggressive toward other residents, verbally aggressive toward staff, physically aggressive toward other residents, physically aggressive toward staff, verbally aggressive toward other residents, grabbing/hitting/kicking/scratching/anger/screaming towards others, wanders in co-resident rooms, rummaging, throwing furniture, agitated/anxious/restless, and takes others' belongings. Review of a nurses' note dated [DATE] at 1:15 P.M. revealed this writer returned to pod from receiving medications from pharmacy shipment and certified nursing assistants (CNAs) reported that Resident #8 hit a co-resident [Resident #155]. CNAs stated that co-resident [Resident #155] slammed a dining room chair into the table and then Resident #8 pushed co-resident [Resident #155] on abdomen. Co-resident [Resident #155] then hit Resident #8 on the back of his head. CNAs stated they separated residents. Resident #8 was assessed with no bruising/redness/skin alterations noted. Vitals obtained. Unit manager (UM) notified, nurse practitioner (NP) notified with new orders to monitor for pain and bruising for three days.Review of a nurses' note dated [DATE] at 1:53 P.M. revealed Resident #8 was observed by staff hitting co-resident [Resident #155] who was attempting to push Resident #8's wheelchair and Resident #8 turned around and struck [Resident #155] in his abdomen. Co-resident [Resident #155] then hit Resident #8 back on the back of his head. Residents immediately separated by staff. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 1:15 P.M. Resident #8 struck a co-resident [Resident #155] in the abdomen and the co-resident [Resident #155] struck Resident #8 on the back of his head. No injuries were observed. Residents were separated and notifications were made. Resident #8 was sent to the hospital on [DATE] for treatment for behavioral disturbance. Review of Resident #155's closed medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, dementia with agitation, depression, anxiety and dysphagia. Resident #8 expired in the facility on [DATE] on hospice services. Review of Resident #155's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #155 had a memory problem, displayed inattention and disorganized thinking, and wandered and had verbal and physical behaviors one to three days in the lookback period.Review of Resident #155's plan of care initiated [DATE] revealed Resident #155 had behaviors related to Alzheimer's dementia as evidenced by wandering/exit seeking, physical aggression, verbal aggression and resisting care.Review of a nurses' note dated [DATE] at 7:35 P.M. revealed upon return to unit from receiving medications from pharmacy CNAs reported that Resident #155 slammed a chair into the table near a co-resident [Resident #8] and co-resident [Resident #8] pushed Resident #155 and he hit co-resident [Resident #8] on the back of his head. CNAs reported they separated residents immediately. No skin alterations/discolorations observed and Resident #155 denied pain or discomfort at this time. UM notified and NP notified with new orders to monitor for pain/bruising for three days.Review of an (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interdisciplinary team (IDT) note dated [DATE] at 3:03 P.M. revealed Resident #155 was observed pushing chairs loudly into the dining room table when nearby co-resident [Resident #8] became agitated by Resident #155's behaviors. Per witness statements of nursing staff present on unit, Resident #155 walked away briefly but returned to the table and began pushing co-resident's [Resident #8's] wheelchair. Co-resident [Resident #8] expressed agitation towards Resident #155 and began to push him and struck him in the abdomen twice. Resident #155 became agitated and struck at the back of co-resident's [Resident #8's] head. Nursing staff present on unit immediately separated residents. Resident #155 was assessed by nurse with no injuries observed at time of incident. Resident #155 interviewed with no changes in daily routine or signs of distress related to incident. Psych NP and UM made aware of incident. Responsible party updated. Resident was monitored for pain/bruising post incident for three days with no documented pain or bruising. Resident without any further documented behaviors or resident to resident altercations at this time.Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 1:15 P.M. Resident #155 was observed striking a co-resident [Resident #8] in the back of his head after co-resident [Resident #8] pushed Resident #155 away and pushed Resident #155 back with his hand to his abdomen. No injuries were observed. Residents were separated and notifications were made.Interview on [DATE] at 3:04 P.M. with the Administrator and the Director of Nursing (DON) revealed while an internal investigation was done with the resident-to-resident altercation involving Resident #8 and Resident #155, they confirmed a self-reported incident (SRI) was not filed as no injury occurred and the residents involved did not have the ability to intend to harm or cause mental anguish.During an interview on [DATE] at 3:36 P.M. Registered Nurse (RN)/Vice President of Clinical (VPOC) #644 provided the surveyor with the abuse flow chart the provider used to help guide their abuse reporting. RN/VPOC #644 was made aware during the interview that applying the reasonable person concept to the above scenario (i.e being punched in the abdomen or the head) could cause injury thus the resident-to-resident altercation should have been reported to the State Agency (SA) as required per the facility's policy.2. Review of Resident #8's closed medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, dementia with mood disturbance, diabetes, bipolar disorder, anxiety, depression and obesity. Resident #8 expired in the facility on [DATE] on hospice services. Review of Resident #8's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #8 had a memory problem, knew the location of his own room, displayed disorganized thinking and inattention, wandered one to three days in the look-back period, showed verbal and other behavioral symptoms one to three days in the look-back period and displayed physical behavioral symptoms four to six days in the look-back period. Review of Resident #8's plan of care initiated [DATE] and revised [DATE] revealed Resident #8 had behaviors related to dementia as evidenced by verbally aggressive toward other residents, verbally aggressive toward staff, physically aggressive toward other residents, physically aggressive toward staff, verbally aggressive toward other residents, grabbing/hitting/kicking/scratching/anger/screaming towards others, wanders in co-resident rooms, rummaging, throwing furniture, agitated/anxious/restless, and takes others' belongings. Review of a nurses' note dated [DATE] at 6:47 P.M. revealed staff had responded to another resident's [Resident #77's] room after hearing, Hey! Get out of my room! Noted co-resident [Resident #77] sitting in wheelchair facing towards the wall eating dinner beside his bed and Resident #8 sitting on the bed. Co-resident [Resident #77] had told this nurse that Resident #8 had just punched him in the face and further stated that Resident #8 had come into his room, got onto his bed and then just punched him in the face. Residents were immediately separated. No injuries noted. NP, Administrator and DON were notified. Resident #8 was put on 15-minute checks. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 5:55 P.M. Staff had responded to another resident's room [Resident #77] after hearing, Hey, get out of my room! Noted co-resident [Resident #77] was sitting in wheelchair facing towards the wall eating dinner beside his bed and Resident #8 was sitting on the bed. Co-resident [Resident #77] told (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this nurse Resident #8 had just punched him in the face and stated Resident #8 had come into his room, got into his bed and just punched him in the face. No injuries were observed. Residents were separated and notifications were made. Resident #8 was placed on 15-minute checks. Review of Resident #77's medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease with late onset, unspecified psychosis, vascular dementia, type two diabetes, personality disorder, anxiety disorder and hyperlipidemia. Review of a quarterly MDS 3.0 assessment dated [DATE] revealed Resident #77 had moderate cognitive impairment and wandered, displayed verbal behaviors, displayed physical behaviors and other behaviors one to three days in the seven-day lookback period. Review of Resident #77's plan of care initiated [DATE] and revised [DATE] revealed Resident #77 had behaviors related to Alzheimer's disease as evidenced by physically aggressive toward staff, verbally aggressive toward staff and wandering throughout facility with no sense of direction. Review of a nurses' note dated [DATE] at 6:54 P.M. revealed staff had responded to Resident #77's room after hearing, Hey! Get out of my room! Noted Resident #77 sitting in his wheelchair facing towards the wall eating dinner beside his bed. Co-resident [Resident #8] was sitting on the bed. Resident #77 had told this nurse that co-resident [Resident #8] had just punched him in the face and had further stated that co-resident [Resident #8] had come into his room, got onto his bed and then just punched him in the face. Residents were immediately separated. No injuries noted. Notified Administrator, DON, NP and emergency contact. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 5:55 P.M revealed staff responded to Resident #77's room after hearing, Hey, get out of my room. Resident #77 was seated in his wheelchair facing towards the wall eating dinner beside his bed. Co-resident [Resident #8] was sitting on the bed. Resident #77 stated co-resident [Resident #8] had just punched him in the face. No injuries were observed. Residents were separated and notifications were made. Interview on [DATE] at 3:04 P.M. with the Administrator and the DON revealed while an internal investigation was done with the resident-to-resident altercation involving Resident #8 and Resident #77, they confirmed a SRI was not filed as no injury occurred and the residents involved did not have the ability to intend to harm or cause mental anguish.During an interview on [DATE] at 3:36 P.M. RN/VPOC #644 provided the surveyor with the abuse flow chart the provider used to help guide their abuse reporting. RN/VPOC #644 was made aware during the interview that applying the reasonable person concept to the above scenario (i.e being punched in the face) could cause injury thus the resident-to-resident altercation should have been reported to the SA as required per the facility's policy.Review of the facility policy, Abuse, Neglect and Exploitation, revised [DATE] revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent and prevent abuse, neglect, exploitation and misappropriation of resident property .the facility will have written procedures to assist staff in identifying the different types of abuse; possible indicators of abuse include but are not limited to physical abuse of a resident observed. The facility will have written procedures that include reporting of alleged violations to the state agency within specified timeframes 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 or result in serious bodily injury. Review of an undated abuse flow sheet titled Examples of Physical Altercations revealed resident to resident physical altercations that must be reported include any willful action that results in physical injury, mental anguish or pain. Willful action had a notation stating having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. Mental anguish had a notation there may be some situations in which the psychosocial outcome to the resident may be difficulty to determine or incongruent with what would be expected. In these situations it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident.3. Review of the medical record revealed Resident #157 was admitted to the facility on [DATE] with diagnoses including hearing loss, cerebral ischemia, asthma, (continued on next page)

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	365720	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Stow	2910 L'Ermitage Pl Stow, OH 44224

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	major depressive disorder, generalized anxiety disorder, and dementia.Review of the quarterly MDS assessment dated [DATE] revealed Resident #157 had severely impaired cognition. Resident #157 had delusions, physical and verbal behaviors, rejection of care, and wandering. Review of the plan of care dated [DATE] revealed Resident #157 had behaviors related to dementia as evidence by exit seeking, physical aggression towards staff, resistant to care verbally aggressive towards staff, wondering in other resident rooms wandering through facility with no sense of direction lower self on the floor, grabbing, kicking, hitting, pushing, cursing at others, anger towards others, screaming, disruptive sounds, wandering in resident rooms, repetitive motion, agitation, anxiety and restlessness, sad and tearful. Interventions included administer medication as ordered and observe for effectiveness and side effects, approach resident in a calm manner to avoid frustration and behavior escalation, communicate care to resident before starting task, if the resident resist with activities of daily living reassure the resident leave and then return later to try again, observe and document episodes of inappropriate behavior, notify the physician or nurse practitioner when behaviors persist or will not deescalate, observe and report any provide positive feedback to the resident when behaviors or changes in mental status caused by situational stressors, observed behavior episodes and attempt to determine underlying cause, offer psychologist and psychiatric services as needed offer resident choices whenever possible provide a calm safe environment when the residents frustrations escalate and allow time to voice feelings, provide a structured schedule for daily care when possible.Review of the medical record revealed Resident #131 was admitted to the facility on [DATE] with diagnoses included vascular dementia, dementia, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, chronic kidney disease, atherosclerotic heart disease, congestive heart failure, anxiety disorder, peripheral vascular disease, pain, hypertension, osteoarthritis, diverticulosis, cognitive communication deficit, and major depressive disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #131 had severely impaired cognition.Review of the Incident Audit Report dated [DATE] at 2:15 P.M. revealed a nursing assistant called the nurse over and stated Resident #157 hit Resident #131 in the left side of her chest with her hand. The other resident was redirected immediately from Resident #131. The nurse assessed Resident #131 and there was no redness or bruising noted to the area, vital signs were blood pressure (B/P) 125/76, pulse (AP) 72, respirations (R) 16, oxygen level 97 percent (%) on room air (RA). The physician and family were notified with a new order to monitor the area for pain or bruises for three days. Resident #131 stated it did hurt but she did not know why the other resident had hit her.Review of the Physical Aggression Form dated [DATE] at 2:15 P.M. revealed there was a section for witness statements. Certified Nursing Assistant #625 stated she was discarding trash and heard yelling, she looked out in the common area and saw Resident #157 hit Resident #131 in the chest, and she immediately stepped in to move Resident#157 away.On [DATE] at 3:25 P.M. an interview with the Director of Nursing revealed they did not do a Self-Reported Incident because she did not believe Resident #131 sustained an injury which needed to be reported. Review of the facility policy, Abuse, Neglect and Exploitation, revised [DATE] revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent and prevent abuse, neglect, exploitation and misappropriation of resident property. Physical Abuse included but was not limited to hitting, slapping, punching, biting and kicking, The facility will have written procedures to assist staff in identifying the different types of abuse; possible indicators of abuse include but are not limited to physical abuse of a resident observed. The facility will have written procedures that include reporting of alleged violations to the state agency within specified timeframes 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 or result in serious bodily injury.This deficiency represents non compliance investigated under Complaint Number 1295325 and 2611622.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of the facility policy, the facility failed to timely report allegations of abuse to the State Agency (SA) as required. This affected five residents (#8, #77, #131, #155 and #157) out of 21 residents reviewed for abuse. Facility census was 131.Findings include:1. Review of Resident #8's closed medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, dementia with mood disturbance, diabetes, bipolar disorder, anxiety, depression and obesity. Resident #8 expired in the facility on [DATE] on hospice services. Review of Resident #8's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 had a memory problem, knew the location of his own room, displayed disorganized thinking and inattention, wandered one to three days in the look-back period, showed verbal and other behavioral symptoms one to three days in the look-back period and displayed physical behavioral symptoms four to six days in the look-back period. Review of Resident #8's plan of care initiated [DATE] and revised [DATE] revealed Resident #8 had behaviors related to dementia as evidenced by verbally aggressive toward other residents, verbally aggressive toward staff, physically aggressive toward other residents, physically aggressive toward staff, verbally aggressive toward other residents, grabbing/hitting/kicking/scratching/anger/screaming towards others, wanders in co-resident rooms, rummaging, throwing furniture, agitated/anxious/restless, and takes others' belongings. Review of a nurses' note dated [DATE] at 1:15 P.M. revealed this writer returned to pod from receiving medications from pharmacy shipment and certified nursing assistants (CNAs) reported that Resident #8 hit a co-resident [Resident #155]. CNAs stated that co-resident [Resident #155] slammed a dining room chair into the table and then Resident #8 pushed co-resident [Resident #155] on abdomen. Co-resident [Resident #155] then hit Resident #8 on the back of his head. CNAs stated they separated residents. Resident #8 was assessed with no bruising/redness/skin alterations noted. Vitals obtained. Unit manager (UM) notified, nurse practitioner (NP) notified with new orders to monitor for pain and bruising for three days. Review of a nurses' note dated [DATE] at 1:53 P.M. revealed Resident #8 was observed by staff hitting co-resident [Resident #155] who was attempting to push Resident #8's wheelchair and Resident #8 turned around and struck [Resident #155] in his abdomen. Co-resident [Resident #155] then hit Resident #8 back on the back of his head. Residents immediately separated by staff. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 1:15 P.M. Resident #8 struck a co-resident [Resident #155] in the abdomen and the co-resident [Resident #155] struck Resident #8 on the back of his head. No injuries were observed. Residents were separated and notifications were made. Resident #8 was sent to the hospital on [DATE] for treatment for behavioral disturbance. Review of Resident #155's closed medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, dementia with agitation, depression, anxiety and dysphagia. Resident #8 expired in the facility on [DATE] on hospice services. Review of Resident #155's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #155 had a memory problem, displayed inattention and disorganized thinking, and wandered and had verbal and physical behaviors one to three days in the lookback period. Review of Resident #155's plan of care initiated [DATE] revealed Resident #155 had behaviors related to Alzheimer's dementia as evidenced by wandering/exit seeking, physical aggression, verbal aggression and resisting care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nurses' note dated [DATE] at 7:35 P.M. revealed upon return to unit from receiving medications from pharmacy CNAs reported that Resident #155 slammed a chair into the table near a co-resident [Resident #8] and co-resident [Resident #8] pushed Resident #155 and he hit co-resident [Resident #8] on the back of his head. CNAs reported they separated residents immediately. No skin alterations/discolorations observed and Resident #155 denied pain or discomfort at this time. UM notified and NP notified with new orders to monitor for pain/bruising for three days. Review of an interdisciplinary team (IDT) note dated [DATE] at 3:03 P.M. revealed Resident #155 was observed pushing chairs loudly into the dining room table when nearby co-resident [Resident #8] became agitated by Resident #155's behaviors. Per witness statements of nursing staff present on unit, Resident #155 walked away briefly but returned to the table and began pushing co-resident's [Resident #8's] wheelchair. Co-resident [Resident #8] expressed agitation towards Resident #155 and began to push him and struck him in the abdomen twice. Resident #155 became agitated and struck at the back of co-resident's [Resident #8's] head. Nursing staff present on unit immediately separated residents. Resident #155 was assessed by nurse with no injuries observed at time of incident. Resident #155 interviewed with no changes in daily routine or signs of distress related to incident. Psych NP and UM made aware of incident. Responsible party updated. Resident was monitored for pain/bruising post incident for three days with no documented pain or bruising. Resident without any further documented behaviors or resident to resident altercations at this time. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 1:15 P.M. Resident #155 was observed striking a co-resident [Resident #8] in the back of his head after co-resident [Resident #8] pushed Resident #155 away and pushed Resident #155 back with his hand to his abdomen. No injuries were observed. Residents were separated and notifications were made. Interview on [DATE] at 3:04 P.M. with the Administrator and the Director of Nursing (DON) revealed while an internal investigation was done with the resident-to-resident altercation involving Resident #8 and Resident #155, they confirmed a self-reported incident (SRI) was not filed as no injury occurred and the residents involved did not have the ability to intend to harm or cause mental anguish. During an interview on [DATE] at 3:36 P.M. Registered Nurse (RN)/Vice President of Clinical (VPOC) #644 provided the surveyor with the abuse flow chart the provider used to help guide their abuse reporting. RN/VPOC #644 was made aware during the interview that applying the reasonable person concept to the above scenario (i.e being punched in the abdomen or the head) could cause injury thus the resident-to-resident altercation should have been reported to the State Agency (SA) as required per the facility's policy. 2. Review of Resident #8's closed medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease, dementia with mood disturbance, diabetes, bipolar disorder, anxiety, depression and obesity. Resident #8 expired in the facility on [DATE] on hospice services. Review of Resident #8's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #8 had a memory problem, knew the location of his own room, displayed disorganized thinking and inattention, wandered one to three days in the look-back period, showed verbal and other behavioral symptoms one to three days in the look-back period and displayed physical behavioral symptoms four to six days in the look-back period. Review of Resident #8's plan of care initiated [DATE] and revised [DATE] revealed Resident #8 had behaviors related to dementia as evidenced by verbally aggressive toward other residents, verbally aggressive toward staff, physically aggressive toward other residents, physically aggressive toward staff, verbally aggressive toward other residents, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grabbing/hitting/kicking/scratching/anger/screaming towards others, wanders in co-resident rooms, rummaging, throwing furniture, agitated/anxious/restless, and takes others' belongings. Review of a nurses' note dated [DATE] at 6:47 P.M. revealed staff had responded to another resident's [Resident #77's] room after hearing, Hey! Get out of my room! Noted co-resident [Resident #77] sitting in wheelchair facing towards the wall eating dinner beside his bed and Resident #8 sitting on the bed. Co-resident [Resident #77] had told this nurse that Resident #8 had just punched him in the face and further stated that Resident #8 had come into his room, got onto his bed and then just punched him in the face. Residents were immediately separated. No injuries noted. NP, Administrator and DON were notified. Resident #8 was put on 15-minute checks. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 5:55 P.M. Staff had responded to another resident's room [Resident #77] after hearing, Hey, get out of my room! Noted co-resident [Resident #77] was sitting in wheelchair facing towards the wall eating dinner beside his bed and Resident #8 was sitting on the bed. Co-resident [Resident #77] told this nurse Resident #8 had just punched him in the face and stated Resident #8 had come into his room, got into his bed and just punched him in the face. No injuries were observed. Residents were separated and notifications were made. Resident #8 was placed on 15-minute checks. Review of Resident #77's medical record revealed an admission date of [DATE] and diagnoses including Alzheimer's disease with late onset, unspecified psychosis, vascular dementia, type two diabetes, personality disorder, anxiety disorder and hyperlipidemia. Review of a quarterly MDS 3.0 assessment dated [DATE] revealed Resident #77 had moderate cognitive impairment and wandered, displayed verbal behaviors, displayed physical behaviors and other behaviors one to three days in the seven-day lookback period. Review of Resident #77's plan of care initiated [DATE] and revised [DATE] revealed Resident #77 had behaviors related to Alzheimer's disease as evidenced by physically aggressive toward staff, verbally aggressive toward staff and wandering throughout facility with no sense of direction. Review of a nurses' note dated [DATE] at 6:54 P.M. revealed staff had responded to Resident #77's room after hearing, Hey! Get out of my room! Noted Resident #77 sitting in his wheelchair facing towards the wall eating dinner beside his bed. Co-resident [Resident #8] was sitting on the bed. Resident #77 had told this nurse that co-resident [Resident #8] had just punched him in the face and had further stated that co-resident [Resident #8] had come into his room, got onto his bed and then just punched him in the face. Residents were immediately separated. No injuries noted. Notified Administrator, DON, NP and emergency contact. Review of an internal risk report [not part of the medical record] revealed an incident audit report dated [DATE] at 5:55 P.M revealed staff responded to Resident #77's room after hearing, Hey, get out of my room. Resident #77 was seated in his wheelchair facing towards the wall eating dinner beside his bed. Co-resident [Resident #8] was sitting on the bed. Resident #77 stated co-resident [Resident #8] had just punched him in the face. No injuries were observed. Residents were separated and notifications were made. Interview on [DATE] at 3:04 P.M. with the Administrator and the DON revealed while an internal investigation was done with the resident-to-resident altercation involving Resident #8 and Resident #77, they confirmed a SRI was not filed as no injury occurred and the residents involved did not have the ability to intend to harm or cause mental anguish. During an interview on [DATE] at 3:36 P.M. RN/VPOC #644 provided the surveyor with the abuse flow chart the provider used to help guide their abuse reporting. RN/VPOC #644 was made aware during the interview that applying the reasonable person concept to the above scenario (i.e being punched in the face) could cause injury thus the resident-to-resident altercation should have been reported to the SA as required per the facility's policy. Review of the facility policy, Abuse, Neglect and Exploitation, revised [DATE] revealed the facility (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent and prevent abuse, neglect, exploitation and misappropriation of resident property .the facility will have written procedures to assist staff in identifying the different types of abuse; possible indicators of abuse include but are not limited to physical abuse of a resident observed. The facility will have written procedures that include reporting of alleged violations to the state agency within specified timeframes 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 or result in serious bodily injury. Review of an undated abuse flow sheet titled Examples of Physical Altercations revealed resident to resident physical altercations that must be reported include any willful action that results in physical injury, mental anguish or pain. Willful action had a notation stating having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. Mental anguish had a notation there may be some situations in which the psychosocial outcome to the resident may be difficulty to determine or incongruent with what would be expected. In these situations it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident. 3. Review of the medical record revealed Resident #157 was admitted to the facility on [DATE] with diagnoses including hearing loss, cerebral ischemia, asthma, major depressive disorder, generalized anxiety disorder, and dementia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #157 had severely impaired cognition. Resident #157 had delusions, physical and verbal behaviors, rejection of care, and wandering. Review of the plan of care dated [DATE] revealed Resident #157 had behaviors related to dementia as evidence by exit seeking, physical aggression towards staff, resistant to care verbally aggressive towards staff, wondering in other resident rooms wandering through facility with no sense of direction lower self on the floor, grabbing, kicking, hitting, pushing, cursing at others, anger towards others, screaming, disruptive sounds, wandering in resident rooms, repetitive motion, agitation, anxiety and restlessness, sad and tearful. Interventions included administer medication as ordered and observe for effectiveness and side effects, approach resident in a calm manner to avoid frustration and behavior escalation, communicate care to resident before starting task, if the resident resist with activities of daily living reassure the resident leave and then return later to try again, observe and document episodes of inappropriate behavior, notify the physician or nurse practitioner when behaviors persist or will not deescalate, observe and report any provide positive feedback to the resident when behaviors or changes in mental status caused by situational stressors, observed behavior episodes and attempt to determine underlying cause, offer psychologist and psychiatric services as needed offer resident choices whenever possible provide a calm safe environment when the residents frustrations escalate and allow time to voice feelings, provide a structured schedule for daily care when possible. Review of the medical record revealed Resident #131 was admitted to the facility on [DATE] with diagnoses included vascular dementia, dementia, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, chronic kidney disease, atherosclerotic heart disease, congestive heart failure, anxiety disorder, peripheral vascular disease, pain, hypertension, osteoarthritis, diverticulosis, cognitive communication deficit, and major depressive disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #131 had severely (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired cognition. Review of the Incident Audit Report dated [DATE] at 2:15 P.M. revealed a nursing assistant called the nurse over and stated Resident #157 hit Resident #131 in the left side of her chest with her hand. The other resident was redirected immediately from Resident #131. The nurse assessed Resident #131 and there was no redness or bruising noted to the area, vital signs were blood pressure (B/P) 125/76, pulse (AP) 72, respirations (R) 16, oxygen level 97 percent (%) on room air (RA). The physician and family were notified with a new order to monitor the area for pain or bruises for three days. Resident #131 stated it did hurt but she did not know why the other resident had hit her. Review of the Physical Aggression Form dated [DATE] at 2:15 P.M. revealed there was a section for witness statements. Certified Nursing Assistant #625 stated she was discarding trash and heard yelling, she looked out in the common area and saw Resident #157 hit Resident #131 in the chest, and she immediately stepped in to move Resident#157 away. On [DATE] at 3:25 P.M. an interview with the Director of Nursing revealed they did not do a Self-Reported Incident because she did not believe Resident #131 sustained an injury which needed to be reported. Review of the facility policy, Abuse, Neglect and Exploitation, revised [DATE] revealed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent and prevent abuse, neglect, exploitation and misappropriation of resident property. Physical Abuse included but was not limited to hitting, slapping, punching, biting and kicking, The facility will have written procedures to assist staff in identifying the different types of abuse; possible indicators of abuse include but are not limited to physical abuse of a resident observed. The facility will have written procedures that include reporting of alleged violations to the state agency within specified timeframes 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 or result in serious bodily injury. This deficiency represents non compliance investigated under Complaint Number 1295325 and 2611622.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, review of medical record, review of facility fall investigation, review of hospital records, review of facility policy and interview, the facility failed to provide comprehensive interdisciplinary monitoring (including input from hospice and Resident #71's son) following an incident on 02/07/26 when the resident was lowered to the floor resulting in a delay in identification and treatment of a left femur fracture, failed to ensure medication parameters were followed per the physician's orders and physician was notified medication was being held for Resident #131, failed to ensure the dressing was changed for Resident #75 per the physician's order, and failed to have a perimeter mattress in place for Resident #12 and #75 per the physician's order. This affected one resident (Resident #71) of nine residents reviewed for change in condition, one resident (Resident #131) of six reviewed for medications, one resident (#75) of two residents reviewed for dressing changes, and two residents (#12 and #75) of three residents observed for perimeter mattresses. Findings include:1.Review of the medical record revealed Resident #71 was admitted to the facility on [DATE] with diagnoses including cerebral atherosclerosis, psychosis, diabetes, diabetic neuropathy, hallucinations, hypertension, dry eye syndrome, macular degeneration, atherosclerotic heart disease, dementia, major depressive disorder, vitreous hemorrhage, and feeding difficulties. Record review revealed Resident #71 was receiving Hospice services. Review of the plan of care with a revision date of 02/13/26 with interventions from 10/04/23 revealed Resident #71 was at risk for pain related to diabetes with diabetic neuropathy, history of rib fractures and left hip fracture. Interventions included administer medication as ordered and observe for side effects and effectiveness (10/04/23), encourage resident to request pain medication prior to pain becoming too intense or prior to activities the resident knows was a potential for increased pain (10/04/23), observe for changes in activity (10/04/23), observe for changes in behavior and mood (10/04/23), observe for changes in sleeping patterns (10/04/23), observe for verbal and non-verbal signs and symptoms relating to pain (10/04/23), and therapy services as needed (10/04/23). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had severely impaired cognition, was independent for mobility and did not have pain. Review of the Alert Note dated 02/07/26 at 4:30 A.M. revealed there was yelling from the room and Resident #71 was attempting to get out of bed. A blanket was under her buttocks and the resident was sliding off the side of the bed. The resident was assisted to the floor onto the left side due to attempts to turn away from the bed. She stated, help me, the flames, put out the flames! The resident was informed there was no smoke, flames, bright lights or heat present. The room was luminated and bed linens removed. The resident was assisted up from the floor and back into bed once she was reoriented and completely awake. Vital signs were obtained and included temperature 97.9, pulse 90, respirations 20, blood pressure 147/82. The resident denied the need for the toilet and asked if her roommate was awake while smiling and pointing across the room. The bed was placed in the low position and call light was within reach. The nurse practitioner and responsible party were notified. There was no evidence Hospice was notified. Review of the Initial Fall assessment dated [DATE] at 4:30 A.M. documented Resident #71 had no pain, no change in range of motion, and no injury or suspected injury. Review of the Fall During Assist incident report dated 02/07/26 at 4:30 A.M. revealed following the incident, the resident would be monitored for pain and bruising for three days. (continued on next page)

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Arbors at Stow	2910 L'Ermitage Pl Stow, OH 44224

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Administration Note dated 02/07/26 at 6:57 P.M. revealed Resident #71 reported soreness to the left lower extremity with no change in transfers or range of motion. Review of Resident #71's Fall-Follow-Up Report dated 02/08/26 revealed the resident's most recent pain level was rated a five (on a scale from zero to 10) at 11:19 A.M. with no documented change in acute pain level related to the incident. The note included the resident's left leg, knee, and hip were more sore than usual but the resident had no change in range of motion. The note included there was not a suspected injury related to the incident identified. Review of Resident #71's February 2026 Medication Administration Record (MAR) and Administration note revealed on 02/09/26 at 5:20 A.M. Resident #71 was administered Acetaminophen 650 milligrams (mg) for mild to moderate pain for a pain level of six out of ten. Review of the Administration note dated 02/09/26 at 12:47 P.M. revealed the Acetaminophen 650 mg for mild to moderate pain for Resident #71 was effective and her pain level was zero. Review of a Pertinent Charting Note dated 02/09/26 at 1:58 P.M. revealed Resident #71 had discoloration noted under the left buttock. The note included there were no signs or symptoms of pain or discomfort noted. Range of motion was at baseline. The nurse practitioner (NP) was notified and gave an order to monitor the area twice a day until healed. Review of Resident #71's MAR and Administration note dated 02/09/26 at 7:21 P.M. revealed Resident #71 was administered Acetaminophen 650 milligrams for mild to moderate pain for complaint of left lower leg pain status post fall on 02/07/26 for pain level rated nine out of ten. Review of the Administration Note dated 02/09/26 at 8:57 P.M. revealed the medication was effective and the resident's pain decreased to zero. Review of an NP note written by NP #649 dated 02/09/25 revealed Resident #71 was seen resting in the common area eating lunch in the dining room. The note referenced the resident had been lowered to the floor by nursing staff on 02/07/26 at approximately 4:20 A.M. The resident thought her bed was on fire and was attempting to escape the flames. Staff noted the resident was yelling out and immediately assessed the resident at her bedside. The resident was noted to have a blanket under her buttocks which was causing her to slide off the side of the bed. The staff assisted the resident by lowering her to the floor to avoid her from falling. The resident was noted to have a discoloration to the left buttock about a quarter sized bruise. On examination the resident denied uncontrolled pain, reported her hip was sore with a five out of ten-pain level. The staff denied any reports of uncontrolled pain. She had been utilizing Acetaminophen as need which had been effective. The resident did have an order for Morphine per hospice care; however, she was declining to utilize the Morphine at this time. The resident was ambulating with her walker and was bearing full weight on the left lower extremity. She endorsed mild pain on palpitation to the left hip. Review of the MAR and Administration Note dated 02/10/26 at 11:47 A.M. revealed Resident #71 was administered Acetaminophen 650 milligram for mild to moderate pain for pain rated an eight out of ten. Review of the Administration note dated 02/10/26 at 2:22 P.M. revealed the medication was effective and the resident's pain decreased to zero. Review hospice visit note dated 02/10/26 revealed upon arrival Resident #71 was awake sitting in a wheelchair in the room. The nurse indicated the resident had fallen out of bed early Monday morning and had a bruise to her left buttock. Upon assessment a small bruise was noted on the back of the resident's left upper leg buttock area. The resident was able to rise from the wheelchair but was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noticeably favoring her left leg, a small bruise was also noted on the side of her left knee as well. The resident stated she fell early Saturday morning after she woke up and thought the room was on fire she stated when she tried to get up she got tangled in her sheets and fell out of bed. She stated her pain was an eight out of ten. The Hospice physician was notified and ordered x-rays of the left hip and knee, the resident's son was updated and stated his mother seemed to be in a lot of pain when he visited her on Sunday. The facility was also reminded to call Hospice with any falls or changes in condition. Review of Resident #71's Fall-Follow-Up Report dated 02/10/26 revealed there was no change in the resident's pain level. Review of NP #649's note dated 02/11/25 revealed Resident #71 was sitting on the side of her bed. Her family was at the bedside and expressed no concerns. The NP was contacted by the Hospice Registered Nurse (HRN) the day before and notified Resident #71 had complained of an eight out of ten left hip pain and left knee pain. It was discussed with the hospice nurse that the resident had been lowered to the floor on 02/07/26 and had a quarter size bruise but the resident had not complained of uncontrolled pain to the staff. Hospice requested x-rays which the NP had initially ordered; however, after discussion with the staff the x-rays were discontinued due to clarification the resident had not fallen but was lowered to the floor and there were no complaints to the NP or the staff of uncontrolled pain. Prior to the visit today hospice staff had contacted the NP and stated the family was requesting x-rays due to the resident complaining of pain. A left hip and left knee x-ray was ordered at this time. The NP spoke with the resident's son via telephone call and he explained his mother had been complaining of increased left hip pain since Saturday. He stated he knew she had not fallen but was lowered to the floor and the NP explained to him the resident had not had any complains of severe or uncontrolled pain to the NP or staff; however, she apparently expressed pain to the hospice nurse. The son stated he understood some residents expressed pain differently. The NP explained to him why the x-rays were cancelled and explained again the resident had not had any uncontrolled pain thus the goal was to avoid unnecessary radiation and imaging. The NP explained she had a low suspicion of there being a fracture but had ordered for the x-rays to be completed due to his request to have them done. The son had no further concerns at the end of the telephone call. Upon examination the resident was unable to specify her pain on a numeric scale. She reported Acetaminophen was effective. Hospice and the NP both offered as needed Morphine and the resident refused. Her family stated the resident had concern of becoming addicted to the pain medication. The NP reassured the resident and family the Morphine was appropriately ordered and when taken in the appropriate setting the risk of addition was very low. The resident's left hip was palpated, and the resident expressed moderate pain with more pain to the left knee. The resident was ambulating with her walker per her usual per staff and family. After the visit the x-ray results were negative for a left knee fracture. The left hip x-ray findings indicated there was an irregularity of the subcapital region, suspicious for subcapital fracture possibly with slight displacement. Conclusion probable subcapital fracture and recommend follow up studies for confirmation. The NP contacted the radiologist, and she was unable to accurately assess the image due to the glare. The NP contacted the orthopedic surgeon, and he recommended the resident be sent to the emergency room (ER) for an evaluation. The son wanted the resident sent to the ER. Review of the February 2026 Medication administration record revealed on 02/11/26 at 11:26 A.M. Resident #71 was administered Acetaminophen 650 milligrams for mild to moderate pain for pain rated an eight out of ten. Review of the Interdisciplinary Progress note dated 02/11/26 at 12:04 P.M. revealed the team (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severely impaired cognition. Review of the August 2025 physician's orders revealed Resident #131 had orders for Amlodipine 10 milligrams one tablet in the morning hold if systolic blood pressure (BP) was less than 120, Hydrochlorothiazide 25 milligrams one tablet in the morning hold if systolic BP was less than 120 and Lisinopril 40 milligrams one tablet every morning hold if systolic BP was less than 120. Review of the August 2025 Medication Administration record revealed the blood pressures for Resident #131 were 110/61 on 08/05/25, 105/65 on 08/08/25, 114/72 on 08/09/25, 103/65 on 08/10/25, 110/71 on 08/15/25, 108/48 on 08/17/25, 118/62 on 08/19/25, 118/62 on 08/19/25, 110/58 on 08/22/25, 98/61 on 08/28/25 resulting in Amlodipine, Lisinopril and Hydrochlorothiazide were all held. There was no documentation that a physician or nurse practitioner was notified of Resident #131 having numerous blood pressure requiring her medications to be held. Further review of the August 2025 Medication Administration Record revealed on 08/27/25 the blood pressure for Resident #131 was 115/67 and her the Amlodipine, Lisinopril and Hydrochlorothiazide were not held but administered to the resident. On 03/19/26 at 11:40 A.M. an interview with the Director of Nursing verified the facility did not notify the physician of the medication being held 10 times for the month out August 2025 or the three days in a row it was held from 08/08/25, 08/09/25 and 08/10/25 as the order did not indicate the physician needed to be contacted. She verified the medications should have been held on 08/27/25 but were administered to Resident #131. 3. Review of Resident #75's medical records revealed an admission date of 11/24/25. Diagnoses included surgical amputation of right toes, muscle weakness and dementia. Review of care plan dated 12/29/25 revealed Resident #75 was at risk for skin impairments related to diabetes. Interventions included administer medications as ordered, preventive treatments as ordered and notify physician or any signs or symptoms of infection. Review of MDS assessment dated [DATE] revealed Resident #75 had impaired cognition. Resident #75 required moderate assistance with toileting, and bed mobility and was dependent with transfers. Review of current physician orders dated 03/14/26 revealed orders to cleanse Resident #75's left dorsal foot with normal saline, apply Medihoney (antibacterial wound ointment), calcium alginate (absorbent wound dressing) cover with an absorbent pad and wrap with kerlex every day shift. Review of Treatment Administration Record (TAR) for March 2026 revealed Resident #75's wound care orders dated 03/14/26 had been documented as being completed daily. Observation of wound care on 03/18/26 at 10:28 A.M. for Resident #75 with Licensed Practical Nurse (LPN) #621 revealed a kerlex dressing that was dated 03/16/26. LPN #621 confirmed the date on Resident #75's dressing and stated she believed the dressing was to be done daily and as needed. 4. Review of Resident #75's medical records revealed an admission date of 11/24/25. Diagnoses included surgical amputation of right toes, muscle weakness and dementia. Review of MDS assessment dated [DATE] revealed Resident #75 had impaired cognition and required (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moderate assistance with bed mobility and was dependent with transfers. Review of physician orders dated 01/05/26-March 2026 revealed Resident #75 was ordered an air perimeter mattress to further assist with defining bed boundaries. Observation on 03/16/26 at 9:47 A.M. revealed a clear bag on Resident #75's reclining chair next to his bed that appeared to have mattress pads inside. Resident #75 stated he was unsure what was in the bag. Observation on 03/17/26 at 8:35 A.M. revealed bag remained on Resident #75's reclining chair. Observation of wound care on 03/18/26 at 10:18 A.M. with LPN #621 confirmed the bag of padding on Resident #75's chair. LPN #621 stated she was unsure what was inside the bag and stated it appeared to be some type of perimeter padding. Interview on 03/19/26 at 6:37 A.M. with DON revealed she had not been aware of a bag of possibly padding in Resident #75's room. Observation at time of interview with DON revealed bag had contained a perimeter mattress topper. DON stated hospice may have brought it in and had not informed staff it needed to be applied. Interview on 03/19/26 at 10:13 A.M. with DON confirmed Resident #75's physician orders for a perimeter mattress had been in place since January 2026 and DON stated she was not sure how long the perimeter mattress pad had been in Resident #75's room and it should have been in place. 5. Review of Resident #12's medical records revealed an admission date of 11/03/25. Diagnoses included dementia and cognitive deficits. Review of MDS assessment dated [DATE] revealed Resident #12 had no cognition score due to resident was rarely understood. Resident #12 required moderate assistance with bed mobility and was independent with transfers. Review of care plan dated 02/10/26 revealed Resident #12 was at risk for falls. Interventions included Bari-bed with perimeter mattress. Review of physician orders dated 02/26/26 revealed Resident #12 was ordered a perimeter mattress to bed to further assist with bed boundaries. Interview on 03/19/26 at 10:13 A.M. with DON revealed Resident #12's care plan from February 2026 had included the use of perimeter mattress. DON stated she was unsure when Resident #12 had received the mattress and physician orders had not been put into place until 03/10/26. Observation on 03/23/26 at 11:58 A.M. revealed Resident #12 was resting in bed and had a perimeter mattress. Interview with Resident #12 revealed he was confused and unable to answer questions appropriately. Interview with LPN #634 revealed some residents had recently been given new perimeter mattresses and stated she was unsure if Resident #12 had received one and stated she was unable to recall if Resident #12 had a perimeter mattress previously. This deficiency represents noncompliance investigated under Complaint Number 2611622, 2723634, and 1295325.

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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 observation, interview, record review and review of the facility policy the facility failed to ensure Resident's #7 care planned fall interventions were implemented. This affected one resident (Resident's #7) out of three residents reviewed for falls. The facility census was 131.Findings include:Review of Resident #7's medical record revealed an admission date of 02/19/26 and diagnoses included unspecified dementia, quadriplegia, delusional disorders, Alzheimer's Disease with early onset, anxiety disorder, major depressive disorder and epilepsy. Review of Resident #7's Nursing admission Evaluation dated 02/19/26 included Resident #7 was at risk for falls.Review of Resident #7's care plan dated 02/19/26 and revised 02/27/26 included Resident #7 was at risk for falls/injury related to impaired cognition and decreased safety awareness. Reduce the risk of injury through the next review. Interventions initiated on 02/19/26 included to ensure Resident #7's room was free from accident hazards; place a mat to the floor next to the bed, and the floor mat was changed on 03/09/26 to place a mattress on the floor at bedside. Review of Resident #7's care plan dated 02/19/26 and revised on 02/23/26 included Resident #7 had behaviors related to her diagnoses as evidenced by verbal aggression, yelling out at staff, throwing her legs out of bed, resisting care, being socially disruptive, attention seeking, a history of yelling fire, and pretending to have a seizure and other behaviors to get attention per her Power of Attorney. Resident #7 would remain injury free related to her behaviors through the next review. Interventions included to approach Resident #7 in a calm manner to avoid frustration and behavior escalation and if Resident #7 became agitated and showed signs of escalation, re-approach later.Review of Resident #7's care plan dated 02/19/26 and revised on 03/06/26 included Resident #7 had an ADL self-care performance deficit related to quadriplegia, dementia, fluctuating ADL's, Alzheimer's Disease and cognitive impairment. Resident #7's ADL needs would be met through the next review. Interventions included Resident #7 required the assistance of one person for ADL's and was a two person assist and used a mechanical lift for transfers.Review of Resident #7's physician orders dated 02/20/26 revealed the resident received tube feedings of Jevity 1.5 cal/fiber oral liquid (nutritional supplement), give 65 ml per hour enterally one time a day for supplement tube feed, run at 65 ml per hour for 12 hours, start at 7:00 P.M.Review of the facility incident log revealed Resident #7 had an unwitnessed fall on 02/24/26 at 11:45 P.M.Review of Resident #7's progress notes dated 02/25/26 at 12:13 A.M. revealed Resident #7 was found on the floor next to the bed after reportedly throwing herself out of bed. The fall was unwitnessed. Resident #7 had a hematoma to the left side of the head by the eye and an active nosebleed. 911 was activated and EMS arrived at 12:00 A.M. Resident #7 was transported to the local hospital. All parties were notified.Review of Resident #7's progress notes dated 02/25/26 at 4:15 A.M. revealed Resident #7 returned to the facility following an evaluation at the hospital for her fall. No new physician orders were received and Resident #7 was negative for injuries. Resident #7 would be monitored and neuro checks were in place.Review of Resident #7's admission Minimum Data Set (MDS) assessment dated [DATE] included Resident #7 was cognitively intact. Resident #7 had no impairment of the upper and lower extremities, and was dependent for Activity of Daily Living's (ADL)'s. Resident #7 was dependent for the ability to roll from lying on her back to the left and right side, and return to lying on her back on the bed and for transfers to and from a bed to a chair or wheelchair. Observation on 03/17/26 at 4:27 P.M. with Resident #7 revealed she was sitting in a wheelchair in the common area, steri-strips and a bruise were observed on her forehead, and greenish-yellow with some purple bruising was noted under both eyes. Resident #7 was pleasant but unable to answer questions appropriately.Interview on 03/17/26 at 4:35 P.M. with Registered Nurse (RN) #505 revealed Resident #7 was absolutely confused. RN #505 stated Resident #7 had dementia with psychoses and was able to buck herself out of bed and throw herself on the floor. RN #505 (continued on next page)

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Arbors at Stow	2910 L'Ermitage Pl Stow, OH 44224

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it was her idea to use the mattress instead of the floor mat because the floor mat was not enough. Interview on 03/18/26 at 10:31 A.M. with Power of Attorney (POA) #660 revealed Resident #7 was recently admitted to hospice services, had terrible anxiety and hospice could provide the right medications and care Resident #7 needed. POA #660 indicated Resident #7 could not move her legs, but she could raise her arm and it would fall after she raised it. POA #660 revealed Resident #7 was able to scoot herself to the edge of the bed and roll off onto the floor. POA #660 indicated Resident #7 did this because she liked the attention she received when she rolled onto the floor and she liked the attention she received at the hospital. POA #660 revealed sometimes Resident #7 hit her head on the floor when she rolled off the bed and had to be transported to the hospital. POA #660 stated the floor mat was not enough protection and now there was a mattress on the floor next to the bed. POA #660 revealed Resident #7 yelled, screamed, put her arms and legs over the side of the bed and she was moved to the facility so her behaviors could be better managed. Interview on 03/19/26 at 6:30 A.M. with Director of Nursing (DON) revealed Resident #7 had not resided in the facility very long and quadriplegia was suspected. The DON stated Resident #7's referral from another facility revealed she had quadriplegia but she was not a quadriplegic, and at times Resident #7 tried to stand up but was unable to. The DON stated at times Resident #7 could move herself and could throw herself out of bed, and at other times she could not. The DON indicated it was unable to be determined what caused Resident #7's quadriplegia. Resident #7's mother wanted her at the facility because the facility had more psych services than most places.Observation on 03/19/26 at 7:53 A.M. of Resident #7 with Certified Nursing Assistant/Central Supply/Transportation (CNA/CS/T) #563 revealed Resident #7 was lying in bed and was leaning over the side of the bed. Next to her head was an oxygen concentrator, a wastebasket and a bedside table. CNA/CS/T #563 immediately moved the oxygen concentrator, the wastebasket and bedside table away from Resident #7's head and stated these things were an accident hazard, Resident #7 was a fall risk and could hit her head on them if she fell out of bed. CNA/CS/T #563 indicated she picked Resident #7 up from her previous facility, was told Resident #7 fell often and she was immediately placed on a low bed with a fall mat next to the bed when she arrived at the facility. CNA/CS/T #563 revealed Resident #7 reached over the bed a lot and grabbed and pulled on the floor mat, she grabbed her tube feeding pole, although now she wasn't getting tube feeding, and she grabbed anything else that was close. Resident #7 often yelled out, calling for people who were not in the facility, and she spent a lot of time in the common area.Interview on 03/19/26 at 10:48 A.M. with Nurse Practitioner (NP) #649 and Unit Manager #633 revealed Resident #7 had a diagnosis of quadriplegia when she was a patient in the hospital and at one point was fully quadriplegic. NP #649 stated she was not sure what caused the diagnosis of quadriplegia and no one really knew what happened to her. NP #649 indicated she felt there was a major psych component related to the quadriplegia. NP #649 revealed she was not able to elicit reflexes of Resident #7's lower extremities, and she felt Resident #7's upper body strength was more than she would present when asked. NP #649 revealed she saw Resident #7 scoot herself to the side of the bed, get leverage, and pushed with one hand to push herself off the bed. NP #649 indicated she asked Resident #7 why she did it and she denied that she did it. NP #649 revealed Resident #7's mother told her Resident #7 pushed herself off the bed and onto the floor at her previous facility. NP #649 stated Resident #7 faked seizures, said she had chest pain, threw herself from her bed, yelled fire and was told by Resident #7's mother that she liked the attention and that was why she did these things. NP #649 indicated she felt Resident #7 was sometimes confused and sometimes had moments of clarity and felt she was terminal because she had quite a few physical ailments. Interview on 03/23/26 at 7:41 A.M. with DON revealed Resident #7 probably hit the cement floor when she rolled off the bed. The DON stated Resident #7 now had a thicker mattress by the side of her bed. The DON was made aware of the observation of a bedside table, a waste basket and an oxygen concentrator by Resident #7's head while she was lying in bed. Interview on 03/23/26 at 10:56 A.M. with Licensed Practical Nurse (LPN) #623 revealed she was working on 02/24/26 when Resident #7 experienced a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall. LPN #623 indicated Resident #7 was assisted into bed for the evening and sometime after she was helped into bed the cleaning lady heard screaming. When LPN #623 entered Resident #7's room she found that Resident #7 had thrown herself off the bed and was face down on the floor and was bleeding. LPN #623 indicated Resident #7 had a feeding tube pole next to the bed with the tube feeding machine attached to it. LPN #623 stated Resident #7 might have hit her head on the tube feeding pole but was not sure because the fall was unwitnessed. Resident #7 had a fall mat on the floor and she was lying on the floor mat. Review of the facility policy titled Falls-Clinical Protocol revised 11/02/23 included as part of an initial and ongoing resident assessment, the staff would help identify individuals with a history of falls and risk factors for subsequent falling. The falls section included history of falls, cognitive status/behavioral symptoms, mobility, balance, medications. Based on the assessment an initial plan of care would be developed and implemented to address identified risk. This would be revised as necessary. Goals of the plan of care included reduction of falls, minimize injury from falls and/or prevent falls while maintaining and/or improving resident abilities and quality of life.This deficiency represents non-compliance investigated under Complaint Number 2794898, 1295318, 1295325, and 1295312.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review and staff interview, the facility failed to ensure individualized behavioral health interventions were implemented to meet Resident #77's mental health needs tp prevent suicidal ideation with suicidal attempt. This deficient practice affected one (Resident #77) of two residents reviewed for mood and behavior. The facility census was 131.Findings include: Resident #77 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, personality disorder, and major depressive disorder.Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #77 was cognitively intact and required hands-on assistance of one staff person for activities of daily living.Review of Resident #77's admission documentation revealed he was admitted from a psychiatric hospital, where he had been transferred from an assisted living facility following a suicide attempt involving placing a garbage bag over his head.Review of a nursing progress note dated 06/20/26 at 6:33 P.M. revealed Resident #77's assigned Certified Nursing Assistant (CNA) alerted nursing staff after observing the resident with a plastic bag placed over his head and face while staff were preparing to escort him to dinner. The CNA immediately removed the bag and notified nursing.Upon assessment, Resident #77 stated, I don't want to be here. I can't go on like this, and expressed active suicidal ideation, including a stated plan to attempt self-harm if left unsupervised. The resident repeatedly stated, I should have done it later in the night. If you leave me, I will do it again.Resident #77 was immediately moved to a common area and placed under one-to-one supervision. A safety check was conducted to ensure no potentially harmful items (e.g., sharp objects, strings, or other ligature risks) were in the resident's possession. The physician and guardian were notified. The guardian reported a history of similar behaviors at previous facilities. Resident #77 was subsequently admitted to an inpatient psychiatric hospital for further evaluation and treatment.Review of the care plan for Resident #77 prior to 06/20/25 revealed a problem related to a history of suicidal behaviors. Interventions included general behavioral approaches such as medication administration as ordered, redirection, non-judgmental support, environmental calming strategies, and monitoring/documentation of behaviors. The care plan failed to include specific, measurable interventions to mitigate risk, such as increased supervision levels and/or environmental safety precautions (e.g., restriction or removal of potentially harmful items).Interview with the Director of Nursing (DON) on 03/18/26 at 9:30 A.M. confirmed the care plan did not include measurable interventions to address Resident #77's suicidal ideations and behaviors prior to 06/20/26.Review of the facility policy titled Comprehensive Care Plans, dated 01/01/21, 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, mental, and psychosocial needs identified in the comprehensive assessment.The deficient practice was corrected on 06/24/25 through the following corrective actions:-On 06/24/25, Resident #77 was readmitted from the psychiatric hospital. A room change was completed to relocate the resident closer to the nurse's station. The resident was placed on one-to-one supervision upon return until cleared by the physician.-On 06/24/25, the care plan was revised to include specific interventions, including 15-minute safety checks, room sweeps every two hours, storage of the resident's cell phone charger at the nurse's station, use of a bell in place of a traditional call light, and provision of preferred activities (e.g., coloring books) daily.-On 06/24/25, the social services department reviewed residents with a known history of suicidal ideation and/or attempts to ensure appropriate care-planned interventions were in place. Four residents were identified and had appropriate care plans in place.-On 06/24/25, a root cause analysis was completed (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the Administrator and Director of Nursing.-On 06/24/25, the Director of Nursing educated the social services department on timely identification and care planning for residents with suicidal ideations and behaviors.-On 06/25/25, the Director of Nursing and designee conducted facility-wide nursing education on Resident #77's behavioral health needs and principles of person-centered care.-On 06/25/25, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was conducted to address the incident.-On 06/25/25, the Director of Nursing completed a 30-day look-back review of new admissions to identify any residents admitted with suicidal ideations or attempts. No additional concerns were identified.This deficiency represents noncompliance investigated under Complaint Number 1295322.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, recipe review and review of the facility policy, the facility failed to ensure pureed foods were prepared appropriately. This affected 22 residents (#13, #14, #18, #21, #30, #31, #32, #37, #38, #45, #54, #57, #60, #61, #63, #65, #72, #91, #103, #107, #153 and #154) that received pureed cabbage during the lunch meal on 03/17/26. Facility census was 131.Findings include: Observation on 03/17/26 from 9:50 AM to 10:45 A.M. revealed [NAME] #654, District Manager (DM) #643 and Food and Nutrition Services Director (FNSD) #642 were present for puree preparation. [NAME] #654 stated she needed 27 cabbage portions pureed for the lunch meal and would make 33 portions to allow for some extra. [NAME] #654 took the cabbage out of the oven and temped it with the facility's self-calibrating electronic thermometer which read 205.2 degrees Fahrenheit (F) and portioned 33 four-ounce portions of cabbage along with all of the liquid (not measured out) that was in the pan from the oven into the Robo Coupe (food processor). Over the course of the observation, [NAME] #654 added four tablespoons of thickener and reblended the mixture multiple times before the puree was placed into the steamer for hot holding until the lunch meal.Observation on 03/17/26 starting at 11:25 A.M. revealed [NAME] #654 temped the foods to be served using the facility's self-calibrating electronic thermometer, including puree cabbage, 181 degrees F. The puree cabbage was served using a gray #8-scoop (four ounces). Tray line started at 11:35 A.M. The first cart to Pod F ended at 11:40 A.M., the cart to Pod C ended at 11:52 A.M, the cart to Pod D ended at 12:05 P.M and the cart to Pod E ended at 12:20 P.M. Continued observation throughout trayline revealed when the pureed cabbage was scooped onto the plate, the puree spread across the plate and did not hold its shape.Interview on 03/17/26 at 11:53 A.M. with DM #643 revealed the residents on puree or mechanical soft diets received the puree cabbage at lunch this date. DM #643 confirmed the puree cabbage spread across the plate which was not an appropriate consistency.Observation on 03/17/26 at 12:42 P.M. of a test tray with DM #643 revealed in addition to the main entree in regular consistency, a bowl of the pureed cabbage was sampled. The consistency of the pureed cabbage was still runny and did not hold its shape. Interview with DM #643 at the time of the observation confirmed the puree had broken down while on the steam table and lost some of its consistency.Follow-up interview on 03/17/26 at 1:04 P.M. with DM #643 verified the provided puree recipe recommended to drain off the water/liquid off the cabbage which was not done during the puree preparation observed earlier this date.Review of the facility recipe, Cabbage, Braised, no date revealed a procedure including 1) chop cabbage and steam or boil until tender and 2) drain off excess water and toss lightly with margarine. For pureed, measure out desired number of servings into a food processor.Review of the facility policy, Therapeutic Diets, revised October 2022 revealed diets are prepared in accordance with the guidelines in the approved diet manual and the individualized plan of care.This deficiency represents noncompliance investigated under Complaint Number 2807687.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of the facility policy, the facility failed to ensure call lights were functional as required. This affected four residents (#20, #47, #49 and #52) reviewed out of 16 resident rooms observed for call light functionality. Facility census was 131.Findings include: Observation on [DATE] from 9:42 A.M. to 10:40 A.M. with Director of Maintenance (DOM) #584 revealed the following concerns:-Resident #20 and Resident #49's call lights were tested and did not activate (light up) outside of the room. Interview with DOM #584 at the time of observation confirmed the lights did not activate outside of the room and DOM #584 thought the light bulb went bad. -Continued observation of Resident #47 and Resident #52's call lights revealed when pressed, they did not activate outside of the room and also did not ring at the nurses' station. Interview with Registered Nurse (RN) #586 and DOM #584 verified the call lights did not activate outside of the room or at the nurses' station.Interview on [DATE] at 10:22 A.M. Maintenance Assistant (MA) #520 revealed call lights not working was an on-going issue at the facility and he was sure some were outstanding.Interview on [DATE] at 10:40 A.M. with DOM #584 during review of electronic work orders revealed the call lights for Residents #20, #47, #49 and #52 had not been reported as broken and needing repair.Review of Work Orders as of [DATE] for [DATE] to [DATE] did not reveal any of the identified rooms for call lights not working had been reported.Review of the facility policy, Call Lights: Accessibility and Timely Response, revised [DATE] revealed staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access the call light .staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and provides immediate or alternative solutions until the problem can be remedied.This deficiency represents non compliance investigated under Complaint Number 2807675.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, record review and review of the facility policy the facility failed to ensure air temperatures remained in required ranges and failed to maintain wheelchairs in a clean and sanitary manner. This affected 48 residents (Resident #5, #18, #27, #47 and #52), all 21 residents on D pod (Residents #2, #8, #14, #15, #17, #22, #25, #33, #38, #44, #58, #61, #78, #83, #84, #88, #92, #97, #115, #149 and #150), and all 22 residents on E pod (Residents #10, #24, #35, #41, #43, #48, #53, #54, #56, #63, #66, #71, #72, #81, #86, #87, #89, #93, #95, #96, #114, #118 and #148). Facility census was 131.Findings include: 1. Observation on 03/19/26 from 9:42 A.M. to 10:40 A.M. with Director of Maintenance (DOM) #584 revealed the following air temperatures were obtained with the facility's laser thermometer:-Resident #47 and Resident #52's room had a temperature of 68.2 degrees F.-Resident #5 and Resident #18's room had a temperature of 69.3 degrees F.-Resident #27's room had a temperature of 69.1 degrees F.-Resident #2 and Resident #58's room had a temperature of 68.9 degrees F.-The main area on Pod D had a temperature of 70 degrees F.-Resident #14's room had a temperature of 67.6 degrees F.-The main area on Pod E had a temperature of 68 degrees F.-Resident #56 and Resident #71's room had a temperature of 70.3 degrees F.-Resident #148's room had a temperature of 69.8 degrees F.The above temperatures were verified by DOM #584 at the time of observation, who also confirmed the acceptable range within the facility was between 71 degrees F and 81 degrees F.Interview on 03/19/26 at 10:22 A.M. with Maintenance Assistant (MA) #520 revealed he had been recording the air temperatures with the facility's orange laser thermometer used this date for the last two months and denied recent concerns with the temperatures being outside of the required range, including under 71 degrees F.Interview on 03/19/26 at 10:40 A.M. with DOM #584 during review of electronic work orders and temperature logs revealed there were no open work orders for the observed low temperatures identified during the observational tour. DOM #584 acknowledged he questioned the accuracy of the temperature logs as they all said 75 degrees F with no variation across the facility. Review of work orders as of 03/18/26 for 12/01/25 to 03/19/26 revealed none of the identified rooms for lower temperatures had been reported.Review of temperature logs from 03/09/26 to 03/13/26 revealed each sampled temperature was documented as 75 degrees F consistently with no variation across the facility.Review of the facility policy, Safe and Homelike Environment, revised 01/01/22 revealed the facility will provide a safe, clean, comfortable and homelike environment Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range and minimize resident' susceptibility to the loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents the facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit. If and a resident prefers his or her room temperature be kept below 71 degrees F or above 81 degrees F, the facility will assess the safety of this practice on the resident and the resident's roommate.2. Observation on 03/19/26 at 10:00 A.M. on Pod D revealed Resident #14 was seated in his wheelchair near the nurses' station. The wheelchair was covered in different colors of debris and was noticeably dirty. Interview on 03/19/26 at 10:00 A.M. with Therapy Program Director (TPD) #648 verified the observed condition of Resident #14's wheelchair. TPD #648 stated Resident #14's wheelchair was supposed to be cleaned on Monday [03/16/26] on night shift and confirmed it did not appear that this was completed.Interviews on 03/19/26 at 12:01 P.M. and 12:40 P.M. with Unit Manager (UM)/Licensed Practical Nurse (LPN) #521 revealed nurses and unit managers were to oversee the initiation and completion of the Pod's wheelchair cleaning schedule by Certified Nursing Assistants (CNAs) and if this was not done, staff were to be disciplined. UM/LPN #521 verified the facility did not have a policy relative to cleaning wheelchairs. Review of the D-Pod Wheelchair Cleaning Schedule, no date, revealed that Resident #14 was to have his wheelchair cleaned on Mondays and Fridays.This deficiency represents non compliance investigated under Complaint Number 2807675, 2807687, and 1295320.