

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER Arbors at Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 Port Sylvania Drive Toledo, OH 43617	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure interventions were in place for significant weight loss. This affected one (Resident #274) of four reviewed for significant weight loss. The facility census was 77.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #274 was admitted on [DATE]. Diagnoses include myasthenia gravis, benign prostatic hyperplasia, dementia, gastroparesis, anxiety disorder, depression, paraplegia (paraparesis), and muscle weakness.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], revealed the resident had mild cognitive impairment and required partial to moderate assistance for toileting and showering. Further, the resident required setup assistance for eating and personal hygiene.</p> <p>Review of Resident #274's weight record revealed a significant weight loss noted between the dates of 01/30/25 (admission) and 06/10/25. On 01/30/25 Resident #274 weighed 165 lbs. On 05/03/25 (prior to hospitalizations) Resident #274 weighed 147.3 lbs (-10.91% since admission) and on 06/10/25 the resident weighed 133 lbs (-19.39% since admission).</p> <p>Review of Resident #274's medical record revealed no interventions were in place to address the resident's weight loss. Additionally, no progress notes or assessments by the dietician or nursing staff were noted in the medical records.</p> <p>Interview with Unit Manager (UM) #368 on 06/10/25 at 10:57 A.M. revealed Certified Nursing Aides (CNAs) are responsible for obtaining residents weights and if any changes were noted, then the resident would be weighed more often. If there are any significant weight loss noted the dietician would be contacted for interventions.</p> <p>Interview with the Director of Nursing (DON) on 06/10/25 at 11:05 A.M. revealed the dietician is responsible for monitoring residents weight. The DON was not aware of Resident #274's significant weight loss.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Dietician #410 on 06/10/25 at 11:31 A.M. revealed that she is in facility every Wednesday and reviews all residents weights and they are also reviewed in meetings. If weight loss is noted, then a supplemental nutrition drink is offered and medications that may cause weight loss are reviewed. Additionally, if any significant weight loss is noted, the DON is notified. Dietician #410 also stated that she didn't know why interventions were not put in place for Resident #274.</p> <p>Interview with Resident #274 on 06/10/25 at 11:54 A.M. revealed he doesn't get enough food to eat and he doesn't like the food the facility serves. Resident #274 also indicated that he was concerned with his weight loss but doesn't know if he expressed that to the facility.</p> <p>Interview with Physician #400 on 06/10/25 at 2:15 A.M. revealed he was aware of the weight loss and the dietician should have been aware. Furthermore, Physician #400 revealed the dietician will give nutrition recommendations and the physician will sign off on them.</p> <p>Interview with Licensed Practical Nurse (LPN) #350 on 06/10/25 at 4:22 A.M. revealed that on 05/16/25 LPN #350 had filled out a therapy referral slip indicating weight loss for Resident #274. LPN #350 indicated that she noticed Resident #274's weight loss and that he hadn't been eating much. The therapy referral slip was given to the therapy department but LPN #350 doesn't know if the dietician ever got the referral slip.</p> <p>Interview with Lead Dietician #418 on 06/11/25 at 1:16 P.M. verified significant weight loss for Resident #274 and from what she knows, the facility was encouraging food intake and the resident would order from Uber Eats. Additionally, Lead Dietician #418 did not know why interventions for Resident #274 were not in place.</p> <p>Review of a policy titled, Weight Monitoring Policy, dated 10/30/20 revealed that based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident's clinical condition demonstrates that this is not possible or resident's preference indicate otherwise.</p> <p>This deficiency represents non-compliance under Complaint Number OH00165990.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and policy review, the facility failed to obtain and administer ordered medication for Resident #274 in a timely manner. This affected one (#274) of four residents reviewed for medication administration. The facility census was 77.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #274 was admitted on [DATE]. Diagnoses include myasthenia gravis, benign prostatic hyperplasia, Dementia, gastroparesis, anxiety disorder, depression, paraplegia (paraparesis), and muscle weakness.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], revealed the resident had mild cognitive impairment and required partial to moderate assistance for toileting and showering. Further, the Resident required setup assistance for eating and personal hygiene.</p> <p>Further review of the medical record for Resident #274 revealed upon admission, the resident had a medication order for Pyridostigmine Bromide 30 milligrams (mg) three times a day. Pyridostigmine is a medication ordered to treat a condition called myasthenia gravis which affects muscle control. The medication omission was not discovered until a hospital admission on [DATE]. Upon Resident #274's discharge on [DATE] the medication was ordered again to be dispensed to resident at the facility.</p> <p>Review of the Medication Administration Record (MAR) dated May 2025 and June 2025 revealed the medication Pyridostigmine Bromide was not given due to unavailability between 05/30/25 and 06/02/25 for a total of nine missed doses.</p> <p>Review of document titled Pharmacy Packing Slip dated 06/02/25 revealed the medication was delivered, but next to the medication on the packing slip, a hand written note indicated the medication was returned due to the resident being admitted to the hospital. Additionally, a pharmacy packaging slip dated 06/06/25 indicated the medication was delivered.</p> <p>Interview with Physician #400 on 06/10/25 at 2:15 P.M. revealed the physician was not aware of the of the order for the medication until Resident #274 came back from the hospital on [DATE]. Physician #400 further stated that without the medication Resident #274 could have muscle decline and fatigue and it is possible that could be part of the reason for the resident's decline.</p> <p>Interview with the Director of Nursing (DON) on 06/10/25 at 2:43 P.M. revealed when a hospital discharges a resident back to the facility, any medications orders would be put in by the nurses. Unit managers are responsible for doing the chart audits on all residents and part of the audit is medication orders. Further, the DON was not aware of the medication error and believes the order was just missed. The DON also indicated that the facility gets two shipments a day from pharmacy so no drop shipment for this medication would have been necessary.</p> <p>Review of policy titled, Medication Administration, dated 10/30/20 revealed that medications are to be administered as ordered by the physician. Additionally, any discrepancies should be corrected and reported to the nurse manager.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00165123.</p>