

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 12/18/2025
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 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 medical record review, facility investigation documents, review of an incident and accident log, review of a performance improvement document, staff interview, and review of a facility policy, the facility failed to ensure appropriate medications were ordered upon admission to prevent significant medication errors. This affected one (#100) of three residents reviewed for medications. The facility census was 70. Findings include: Review of the medical record for Resident #100 revealed an admission date of 08/18/25 and a discharge date of 09/03/25. Diagnoses included depression and displaced Maisonneuve fracture of the left leg (severe ankle injury that caused a spiral fracture in the tibia bone of the leg). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #100 revealed the resident was cognitively intact. Review of the community referral form (CRF; a document on which admitting physician orders are obtained from for continued medication compliance) dated 08/18/25 for Resident #100 revealed no physician order for the antipsychotic medication, Seroquel 100 milligrams (mg). Further review of the CRF for Resident #100 revealed an order for the antidepressant medication sertraline 100 mg daily. Review of a physician order dated 08/18/25 for Resident #100 revealed Seroquel 100mg was ordered upon admission to the facility. Review of Resident #100's August 2025 medication administration record (MAR) revealed Seroquel 100 mg was administered on 08/19/25 for the morning dose. Review of the incident and accident log for August 2025 revealed a medication error for Resident #100 where a transcription error occurred, and Resident #100 received one dose of Seroquel 100 mg instead of the correct order for sertraline 100 mg. Review of the facility's investigation for a medication error dated 08/19/25 revealed Resident #100 was involved in a medication error where a medication was transcribed incorrectly on admission. Resident #100 was ordered sertraline 100 mg and Seroquel 100mg was ordered in error. Resident #100 was administered Seroquel 100mg in error on 08/19/25. Review of the performance improvement form for Licensed Practical Nurse (LPN) #300 revealed LPN #300 was provided education on transcription of medications and verification with a second nurse. Interview on 12/17/25 at 10:44 A.M. with Registered Nurse (RN) #350 verified the medication error that involved Resident #100 for the administration of Seroquel 100 mg on 08/19/25. RN #350 verified the medication to be administered should have been sertraline 100 mg. RN #350 stated she identified the medication error the day after Resident #100's admission on [DATE] when she reviewed the medications for admission. RN #350 stated by the time she identified the medication error the morning dose of Seroquel 100 mg had already been administered. RN #350 stated the physician was notified and the provider ordered the facility to monitor Resident #100. RN #350 stated ideally the nurses should have a second verification upon admission and that did not happen. Review of the facility policy titled, Medication Administration, revised 01/17/23, revealed medications are administered by licensed nurses or other staff who are legally authorized to do so in the state, as ordered by the physician. This deficiency represents non-compliance investigated under Complaint Number 2612349.</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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