STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366060	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Sylvania	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident and staff interview, and policy review, the facility failed to ensure resident bathrooms and shower rooms were kept in a clean and sanitary manner, and in good repair. This affected 11 residents (#20, #23, #24, #29, #35, #40, #54, #59, #60, #70, and #73) residing on the 400 hall and 39 residents (#1, #2, #3, #6, #7, #13, #14, #17, #18, #21, #25, #26, #27, #31, #32, #33, #34, #36, #37, #38, #39, #42, #43, #44, #47, #48, #49, #50, #52, #53, #55, #56, #58, #62, #63, #64, #66, #69, and #72) on the 100/200 hall. The facility census was 72.Findings include:Observation on 06/29/26 at 9:46 A.M. with Housekeeping Group Manager (HGM) #300 of the shared bathroom for Resident #20 and Resident #73 revealed there was a buildup of debris and grime in the bathroom corners, dust on the air vent above the toilet, stained flooring, and the shower tiles had a buildup of a black/brown substance in the grout lines.Interview on 06/29/26 at 9:46 A.M., with HGM #300 verified the condition of the bathroom. HGM #300 revealed it was on the list to clean the grout in the showers. Observation on 06/29/26 at 9:51 A.M. of Resident #29 and Resident #35's shared bathroom revealed there was a rusted and exposed drywall seam with missing drywall at the entrance to the shower.Interview on 06/29/26 at 9:51 A.M., with HGM #300 verified the exposed drywall seam with missing drywall. HGM #300 revealed staff should have reported about the area. Observation on 06/29/26 at 9:53 A.M. in Resident #54 and Resident #59's shared bathroom revealed there was a buildup of a black-brown substance on the tile grout lines in the shower.Interview on 06/29/26 at 9:53 A.M., with HGM #300 verified the presence of the black/brown substance on the shower tiles. Observation on 06/29/26 at 9:56 A.M. in Resident #70 and Resident #23's shared bathroom revealed a buildup of black-brown discoloration on the edges of the shower floor, a buildup of debris/grime on the floor behind the toilet, and rust discoloration on the bathroom air vent. Interview on 06/29/26 at 9:56 A.M., with HGM #300 verified the findings in Resident #70 and Resident #23's bathroom.Observation on 06/29/26 at 10:00 A.M., of Resident #40 and Resident #24's shared bathroom revealed the shower light was not working, there were stained floors behind the toilet, and a patched area of drywall on the wall with broken pieces and no paint.Interview on 06/29/26 at 10:00 A.M., with HGM #300 verified the shower light was not working, the stained floors and the area of drywall in disrepair. Observation on 06/29/26 at 10:03 A.M. in Resident #60's bathroom revealed a buildup of a black-brown substance on the tile grout lines in the shower and a buildup of debris/grime on the floor behind the toilet.Interview on 06/29/26 at 10:03 A.M., with HGM #300 verified the buildup of the black-brown substance on the tile and grime behind the toilet. Observation on 06/29/26 at 11:34 A.M. with Director of Maintenance (DOM) #226 in the shower room on the 100/200 hall revealed two of the shower stalls had a heavy buildup of a black-brown substance on the tile grout lines and in the corners of the shower walls near the floor. Additionally, there were greater than 90 black circular spots surrounding the ceiling air vent in the shower room/bathroom. Interview on 06/29/26 at 11:34 A.M., with DOM #226 verified the shower room needed cleaned and stated he would report the condition of the shower room to HGM #300. Interview on 06/30/26 at 9:22 A.M., with Resident #73 revealed her family member had assisted her with a shower and the family member lifted her legs so they would not touch the shower floor because she was scared of what looked like black mold on the shower floor. Resident #73 revealed (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366060	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Sylvania	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she had not reported the condition of the shower to staff. Observation on 06/30/26 at 10:25 A.M. in the shower room on the 100/200 hall revealed there were still greater than 90 black circular spots surrounding the ceiling air vent in the bathroom. Also, there was still a buildup brown-black debris in the corners of the two shower stalls. Interview on 06/30/26 at 10:25 A.M., with Certified Nurse Aide (CNA) #228 verified the black circular spots on the ceiling in the shower room. CNA #228 revealed the condition of the shower room and resident bathrooms had been reported numerous times to housekeeping. Interview on 06/30/26 at 10:44 A.M., with the Administrator verified all residents residing on the 100/200 hall were using the shower room. Further interview on 06/30/26 at 10:58 A.M., the Administrator verified the presence of the black circular spots on the ceiling in the shower room. Review of the facility policy titled, 7-Step Daily Washroom Cleaning, dated 10/25/16, revealed staff would mop the floor with disinfectant daily. Also, staff were to run the mop along the edges and never push dirt into the corners. Further review of the policy revealed no guidelines for cleaning ceilings. Review of the facility policy titled, Routine Bathroom Cleaning, revised 02/01/22, revealed the facility would establish policies, procedures, and guidelines to provide a clean and sanitary environment for residents, staff, and visitors in order to prevent cross contamination and transmission of healthcare-associated infection. Further review of the policy revealed staff would report areas of mold, cracked, leaking, or damaged items in need of repair. This deficiency represents non-compliance investigated under Master Complaint Number 3047691.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366060	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Sylvania	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)
F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the facility's resident appointment calendar, resident interview, and staff interview, the facility failed to ensure transportation was timely scheduled for an echocardiogram. This affected one (#7) of three residents reviewed for medical appointments and transportation. The facility census was 72. Findings include:Review of the medical record for Resident #7 revealed an admission date of 12/08/23. Diagnoses included type two diabetes mellitus, congestive heart failure, atrial fibrillation, hypertension, chronic kidney disease stage three, and the presence of a cardiac pacemaker. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had mild cognitive impairment. Review of the care plan last revised 12/15/25 revealed Resident #7 had impaired cardiovascular status related to atrial fibrillation, coronary artery disease, heart failure, hypertension, pacemaker placement, obesity, chest pain, and hyperlipidemia. One of the interventions included for staff to ensure the completion of laboratory tests and diagnostic testing as ordered. Review of Resident #7's physician after visit summary dated 03/17/26 revealed physician orders for an echocardiogram without contrast. Review of a physician after visit summary dated 04/29/26 revealed Resident #7 had an appointment for an echocardiogram to be completed on 05/28/26 at 10:45 A.M. Review of a handwritten facility calendar dated 05/28/26 revealed Resident #7 had an appointment scheduled for an echocardiogram at 10:45 A.M. Above the appointment was the handwritten word, Transport, followed by a question mark.Review of Resident #7's medical record revealed no documentation the echocardiogram was completed on 05/28/26.Review of Resident #7's laboratory results progress note dated 06/25/26 revealed the echocardiogram was not completed until 06/25/26. Review of the nursing progress notes dated 03/17/26 through 06/28/26 revealed no documentation regarding Resident #7's appointment and transportation for the echocardiogram. There was no documentation the procedure was not completed on 05/28/26 and there was no documentation about why or when the procedure was rescheduled. Interview on 06/29/26 at 10:05 A.M., with Registered Nurse (RN) #202 revealed Resident #7 had an appointment for a cardiology procedure about a month ago and no transportation had been set up for the appointment. RN #202 revealed the resident's family member was very upset. Interview on 06/29/26 at 2:22 P.M., with Resident #7 stated she missed a cardiology appointment because the facility forgot to get her transportation. Resident #7 was unsure of the date of the appointment. Interview on 06/29/26 at 4:11 P.M., with the Director of Nursing (DON) revealed the floor nurse was responsible to enter an order for a scheduled appointment and also to arrange transportation for the appointment. Interview on 06/30/26 at 8:34 A.M., with Unit Manager Licensed Practical Nurse (UM LPN) #212 revealed she was off work on leave until 06/01/26. UM LPN #212 verified Resident #7 did not go to the appointment for the echocardiogram on 05/28/26. UM LPN #212 verified there was no documentation in the medical record the appointment had been missed or rescheduled. UM LPN #212 verified the nurses should have documented the missed appointment and the rescheduled appointment in the medical record. Interview on 06/30/26 at 8:42 A.M., with RN #214 revealed she scheduled the resident's echocardiogram on 05/28/26 and wrote the appointment down on the calendar. RN #214 revealed the insurance company usually would not allow transportation to be set up too far in advance for an appointment and she had not set up transportation for the appointment. RN #214 confirmed she was the staff member who wrote transportation with a question mark next to the resident's appointment. RN #214 revealed she was, not taking responsibility for not setting up the transport for Resident #7's appointment. RN #214 revealed she was not sure who should have set up the transportation. RN #214 revealed the night shift nurses used to ensure transportation for appointments, but their responsibilities had been whittled down.Interview on 06/30/26 at 9:40 A.M., the Administrator revealed she could not find a policy/procedure for arranging resident appointments and transportation. This deficiency represents non-compliance investigated under Complaint Number 2968736.