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	04/17/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident interview and staff interview the facility failed to ensure a comfortable mattress was provided following a request. This affected one (#53) of 24 residents reviewed for reasonable accommodation of needs and requests. The facility census was 73. Findings include: Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including cervical disc disorder with myelopathy, chronic venous hypertension with ulcer of bilateral lower extremity, chronic obstructive pulmonary disorder, type 2 diabetes mellitus, spinal stenosis, benign prostatic hyperplasia, neuromuscular dysfunction of bladder, mood disorder, chronic kidney disease stage 4, hypertension, coronary artery disease, congestive heart failure, and muscle weakness. According to the most current Minimum Data Set (MDS) assessment dated [DATE], Resident #53 had intact cognition, had range of motion impairment to upper and lower bilateral extremities, was dependent on staff for the completion of activities of daily living including bed mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no skin breakdown. On 02/14/25 a skin risk assessment completed for Resident #53 revealed score of 14, indicating moderate risk for developing skin breakdown. According to a physician order dated 12/27/24 a low air loss mattress was to be placed in use, instructions included to monitor function and settings every shift. Observation on 04/14/25 at 9:09 A.M. noted Resident #53 in bed with the air mattress in place. Resident #53 stated the air mattress was partially inflated and his buttock was resting against the bed frame. The resident stated he requested a new mattress in December and one had not been provided. On 04/15/25 at 9:18 A.M. observation with Licensed Practical Nurse (LPN) #527 assessed Resident #53 while in the bed with the air mattress in place. LPN #527 verified Resident #53 buttock in contact with the bed frame. Additional observation noted Resident #53 had no current skin breakdown, however, scaring was identified from previously healed skin breakdown. (continued on next page)

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
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 7:40 A.M. interview with LPN #532 revealed nursing staff are to check Resident #53's air mattress setting each shift. LPN #532 was aware Resident #53 had reported concerns with the comfort of the mattress. LPN #532 stated the air mattress settings were determined appropriate and no attempts to obtained a replacement air mattress had occurred. This deficiency represents non-compliance investigated under Complaint Number OH00163310.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Sylvania	7120 Port Sylvania Drive Toledo, OH 43617

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure interventions to address edema were initiated. This affected one (#01) of two residents reviewed for edema prevention and monitoring. The facility census was 73. Findings include: Review of the medical record revealed Resident #01 admitted to the facility on [DATE] with diagnoses including anoxic brain damage, anxiety disorder, contracture to bilateral hands, elbows and shoulders, localized edema, and chronic pain. According to the most current Minimum Data Set (MDS) assessment dated [DATE], Resident #01 had severely impaired cognition, no refusals of care, bilateral upper and lower extremity range of motion impairment, was dependent on staff for all activities of daily living, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no skin breakdown. Observation on 04/14/25 at 8:55 A.M. noted Resident #01 seated in a specialized wheelchair with bilateral arms resting dependent at her sides. Resident #01's left hand was observed with edema and a closed fist. Observations on 04/15/25 at 5:46 A.M., 11:43 A.M., 12:42 P.M., 04/16/25 at 5:37 A.M., 11:43 A.M., and 12:42 P.M. noted Resident #01 in bed with bilateral arms resting dependently at each side and hands with closed fists. On 04/17/25 at 8:35 A.M. observation with Licensed Practical Nurse (LPN) #523 assessed Resident #01 with one plus pitting edema to the left hand and middle forearm. LPN #523 verified no interventions were contained in the medical record to address Resident #01 history of edema. On 04/17/25 at 8:40 A.M. interview with LPN #529 during review of Resident #01's medical record verified Resident #01 with dependent edema to left hand and forearm. LPN #529 verified Resident #01 did not have interventions in place to address the edema.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure interventions were implemented to prevent deterioration of contractures. This affected one (#01) of two residents reviewed for range of motion and positioning. The facility census was 73. Findings include: Review of the medical record revealed Resident #01 admitted to the facility on [DATE] with diagnoses including anoxic brain damage, anxiety disorder, contracture to bilateral hands, elbows and shoulders, localized edema, and chronic pain. According to the most current Minimum Data Set (MDS) assessment dated [DATE], Resident #01 had severely impaired cognition, no refusals of care, bilateral upper and lower extremity range of motion impairment, was dependent on staff for all activities of daily living, was incontinent of bowel and bladder, and at risk for pressure ulcer development with no skin breakdown. On 08/27/21 a physician order was written to place a washcloth in each of Resident #01's hands to keep fingers from clenching into palms of hands every shift due to bilateral hand contractors. On 08/09/23 a nursing plan of care was implemented to address Resident #01's impaired musculoskeletal status related to contractures with interventions to include for Resident #01 to be free of complications related to altered musculoskeletal status through the next review, administer treatments as ordered, observe for and report to nurse any pain or skin integrity issues related to use of the washcloth in hands, cleanse hands and dry completely prior to application of washcloths in hands, and to provide range of motion (ROM) as indicated prior to use of washcloth in hands to keep fingers from clenching into palms of hands. In addition, on 02/25/24 a nursing plan of care was implemented to address Resident #01's inability to participate in a restorative programs related to the distress it caused her. Resident #01 does not tolerate passive range of motion (PROM) to her bilateral hands as they are severely contracted and when doing PROM Resident #01 has facial grimacing and and starts to cry and scream, and pulling hands away. Interventions included to clean bilateral hands with A.M. and P.M. care, as tolerated. If distress is noted (crying or facial expressions) stop and reapproach as needed. Monitor for signs and symptoms of skin breakdown to bilateral hands. Observation on 04/14/25 at 8:55 A.M. noted Resident #01 seated in a specialized wheelchair with bilateral arms resting dependently at her sides. No washcloths were in place to either hand and both hands fists were closed. Observations on 04/15/25 at 5:46 A.M., 11:43 A.M., 12:42 P.M., 04/16/25 at 5:37 A.M. revealed no washcloths were in place and Resident #01's hands were closed fisted. On 04/16/25 at 10:16 A.M. interview with Certified Nurse Aide (CNA) #569 revealed she assumed care at 6:00 A.M. for Resident #01 and verified no washcloths had been in place to either hand since the beginning of the shift. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 11:45 A.M. interview with Licensed Practical Nurse (LPN) #508 verified washcloth rolls had not been in place as ordered by the physician for Resident #01.

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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 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** 15816 Based on observation, medical record review, staff interview, and facility policy, the facility failed to ensure fall interventions were implemented as indicated. This affected one (#24) of three residents reviewed for fall management. The facility census was 73. Findings include: Resident #24's medical record review revealed the resident admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, cerebral infarction, [NAME] lymphoma, hypertension, seizure disorder, abnormal posture, chronic kidney disease stage 3, coronary artery disease, anemia, traumatic subdural hemorrhage without loss of consciousness, and cardiac arrhythmia. According to the most current Minimum Data Set (MDS) assessment dated [DATE] Resident #24 was assessed with severe cognitive impairment, no recorded refusal of care, utilized a wheelchair for mobility, required substantial to maximal assistance with activities of daily living, incontinent of bowel and bladder. Review of the fall assessment dated [DATE] at 8:06 P.M. noted Resident #24 was found on the floor on the side of the bed. On 03/02/25 at 10:33 P.M. a follow-up fall assessment was completed and indicated new interventions to prevent further injury from falls was implemented. According to progress note dated 03/02/25 at 3:07 A.M., Resident #24 fell out of bed trying to ambulate to the restroom on 03/01/25 and was found sitting on the floor on the side of bed. Resident #24 had no complaints of pain and was assisted with transfer back into bed. Nursing interventions in place included keeping bed in low position, and the call light within reach for assistance. On 03/03/25 at 10:55 A.M. the Interdisciplinary Team progress note documented Resident #24 was found sitting on the floor next to her bed after attempting to ambulate to the bathroom. No injuries were noted and both the physician and family were notified. A new intervention to apply hipsters was implemented. On 03/26/25 a nursing plan of care was revised to address Resident #24's risk for falls/injury related to decreased strength and endurance, generalized weakness, poor balance, and seizures. Interventions included hipsters as tolerated, toileting and repositioning every two hours, taking the resident to the common area when increased anxiety was identified, and encourage the resident to use the call light. Observation on 04/17/25 at 6:37 A.M. noted Resident #24 seated in a wheelchair with her eyes closed. No hipsters were in place. Interview with Licensed Practical Nurse (LPN) #529 at the time of observation verified Resident #24 did not have hipsters applied as indicated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to facility Accidents and Supervision policy revised 12/27/2023. Each resident will be assessed for accident risk and will receive care and services in accordance with their individualized care plan. This included implementing interventions to reduce hazards or risk. Using specific interventions to try to reduce a residents risk from hazards in the environment. Interventions are based on the results of the evaluation and analysis of information about the hazards or risks and are consistent with relevant standards, including evidence-based practice. Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident interview, staff interview, and facility policy the facility failed to ensure timely care and treatment was provided to address incontinence. This affected two (#40 and #63) of five residents reviewed for bowel and bladder incontinence services. The facility census was 73. Findings include: 1. Review of the medical record revealed Resident #40 admitted to the facility on [DATE] with the diagnoses including metabolic encephalopathy, severe protein-calorie malnutrition, depressed mood, stage 2 pressure ulcer to sacral region and left buttock. dysphagia, and anemia. According to the most current Minimum Data Set (MDS) assessment dated [DATE], Resident #40 was assessed with moderately impaired cognition, range of motion impairments to the bilateral upper and lower extremities, dependency on staff for the completion of activities of daily living including bed mobility and incontience care as Resident #40 was always incontinent of bowel and bladder. Resident #40 was at risk for pressure ulcer development and admitted with two stage two pressure ulcers. On 03/24/25 the nursing plan of care was revised to address Resident #40's episodes of bladder and bowel incontinence. Interventions included to assist Resident #40 with toileting needs, check at regular intervals and change as needed, provide disposable incontinence products, provide peri-care after each incontinence episode and apply house barrier cream after incontinence care. No specific interval of incontinence monitoring was contained in the medical record. Review of the task documentation between 03/19/25 and 04/15/25 recorded Resident #40 to be incontinent daily. However, no frequency of check and change was identified. Observation on 04/15/25 at 5:52 A.M. noted Resident #40 in bed positioned to the right. Continued observation between 5:52 A.M. and 9:14 A.M. noted Resident #40 remained in bed on the right side without repositioning or incontinence checks. On 04/15/25 at 6:04 A.M. interview with Certified Nurse Aide (CNA) #537 revealed she assumed the care for Resident #40 on 04/14/25 at 10:00 P.M. and continued care until 04/15/25 at 6:00 A.M. CNA #537 stated Resident #40 required every two-hour incontinence checks and repositioning and was last provided incontinence care and repositioning at 4:30 A.M. Interview on 04/15/25 at 9:14 A.M. with CNA #554 verified she assumed the care for Resident #40 at 6:00 A.M. and had not checked Resident #40 for incontinence or provided repositioning since assuming care at 6:00 A.M. CNA #554 stated she was unaware when Resident #40 was last checked for incontinence or repositioning. Observation on 04/15/25 at 9:31 A.M. with CNA #554 noted Resident #40 was heavily soiled with urine through an adult brief onto linen covering (chux). Two wound dressings were observed to Resident #40 left upper thigh and left sacrum. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #63 revealed the resident was admitted to the facility on [DATE] with diagnoses including, dorsopathy, chronic obstructive pulmonary disease, obstructive sleep apnea, abnormal posture, anxiety disorder, depression, hypertension, and fibromyalgia. According to the most current MDS assessment dated [DATE], Resident #63 was cognitively intact, had the ability to make needs known, and had no history of refusing care. Resident #63 had limited range of motion to bilateral lower extremities, required substantial to maximal assistance with activities of daily living, was dependent on staff for bed mobility, was always incontinent of bowel and bladder, and was at risk for pressure ulcer development with no current skin breakdown. On 12/04/24 a nursing plan of care was revised to address Resident #63 risk for episodes of bowel and bladder incontinence. Interventions included to assist the resident with toileting needs, provide disposable incontinence products, provide peri-care after each incontinence episode and apply in-house barrier cream after each incontinence care. Review of skin assessment dated [DATE] identified a new abnormal skin area with redness and excoriation to the groin. Observation on 04/14/25 at 9:56 A.M. noted Resident #63 in bed. Resident #63 stated she requires every two hour incontinence checks and repositioning and the staff is not providing the care. As a result of not receiving care, Resident #63 stated she developed excoriation and a rash. On 04/15/25 at 5:57 A.M. Resident #63 was observed positioned on her back with eyes closed. Continued observation on 04/15/25 between 5:57 A.M. and 8:04 A.M. noted Resident #63 in bed positioned on her back with no repositioning or incontinence checks or care attempted. On 04/15/25 at 6:07 A.M. an interview with Certified Nurse Aide (CNA) 537 revealed she had provided Resident #63 with incontinence care and repositioning at 4:25 A.M. CNA #537 stated Resident #63 is unaware when she is incontinent and needed to be checked and repositioned every two hours. On 04/15/25 at 8:04 A.M. an interview with Resident #63 revealed she had been incontinent of urine and no checks or repositioning had occurred since night shift. On 04/15/25 at 8:41 A.M. an interview with CNA #554 revealed she was looking for incontinent wipes due to Resident #63 being excoriated. CNA #554 stated she did not want to use rough washcloths. At 09:02 A.M. CNA #554 proceeded to check Resident #63 for incontinence. Resident #63 was observed with excoriated perineum including the pan and groin. Resident #63 was incontinent of a large amount of urine and small formed bowel movement. CNA #554 right upper thigh was also excoriated. Two adult incontinence briefs were discovered under the resident and both were soiled. On 04/15/25 at 9:14 A.M. following resident care, interview with CNA #554 verified the check and change at 9:02 A.M. was the first contact CNA #554 had with Resident #63 since assuming care at 6:00 A.M. CNA #554 was unaware when Resident #63 was last checked, changed or repositioned. CNA #554 verified the resident is to be checked and changed every two hours with repositioning. According to the facility policy titled Incontinence, revised 10/26/2023, stated based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Residents that are incontinent of bladder and bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00163310.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, record review, staff interview, and review of the facility policy, the facility failed to ensure oxygen was running at the prescribed rate. This affected one resident (#29) reviewed for oxygen therapy. The facility identified 15 residents required the use of oxygen therapy. The facility census was 73. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE] with admitting diagnoses of heart failure and end stage renal disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #29 revealed he was cognitively intact and required the use of oxygen. Review of the care plan revised 02/25 for Resident #29 revealed he was care planned for impaired cardiovascular stated related to heart failure with an intervention for oxygen therapy as ordered. Review of the current physician orders for 04/25 revealed Resident #29 was ordered oxygen at two liters per minute continuously via nasal cannula. Observation on 04/14/25 at 11:51 A.M. of Resident #29 revealed he was sitting in his wheelchair with a portable oxygen tank running at three liters per minute. Interview on 04/14/25 at 11:54 A.M. with Licensed Practical Nurse (LPN) #526 verified oxygen for Resident #29 was running on the portable oxygen tank at three liters per minute and verified the order from the physician was for the oxygen to be running at two liters per minute. Review of the facility policy titled Oxygen Administration, revised 10/23 revealed oxygen is administered under orders of physician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and facility policy, the facility failed to ensure alternative and non-pharmacologic interventions were implemented to address pain in accordance with physician orders. This affected one (#177) of two residents reviewed for pain control interventions. The facility census was 73. Findings include: Review of the medical record revealed Resident #177 admitted to the facility on [DATE] with diagnoses including cauda equina syndrome, spinal stenosis lumbar region, abnormal posture, chronic venous hypertension, chronic pain, chronic fatigue, allergy status to unspecified drugs, medications and biological substances, and lumbago with sciatica. According to the most current Minimum Data Set (MDS) assessment dated [DATE], Resident #177 was cognitively intact, was able to make needs known, had limited bilateral lower extremity range of motion, required substantial to maximal assistance with activities of daily living, received scheduled and as needed (PRN) pain medications and had non-medication interventions in place for pain. Review of hospital community referral physician orders dated 04/01/25 noted non-pharmacological wound care instructions to include the application of an ice pack to the surgical incision to help with pain. The ice pack was to be applied 15 to 20 minutes at a time, five to six times daily. On 04/02/25 a nursing plan of care was implemented to address Resident #177 pain related to back surgery, surgical incision, and verbal complaints of pain. Interventions included the following: administer medications as ordered and observe for effectiveness. Offer non-pharmacological interventions to relieve pain and observe for effectiveness. Further review of the plan of care lacked documentation describing specific non-pharmacological interventions. Review of physician orders lacked documentation indicating the ice packs and lacked where and when the ice packs were to be applied. Review of the administration records for Resident #177 lacked documentation regarding the ice packs. Observation on 04/14/25 at 10:00 A.M. noted Resident #177 seated in a wheelchair at the bedside. Interview with Resident #177 stated she was experiencing a pain level of 8 (level zero, no pain and level 10 indicating severe pain) in back, hips, legs. Resident #177 described the pain as a burning sensation. Resident #177 stated she had multiple medication allergies and would like non-pharmacological interventions between scheduled pain medication administrations. The resident stated she had not had any non-pharmacological interventions provided the past two nights. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional interview on 04/15/25 at 5:54 A.M. with Resident #177 stated she spoke with her surgeon and indicated she was to receive ice applications five to seven times daily for 20 minutes and increased the dose of gabapentin. Resident #177 reported a pain level of 5 at the time of the interview. Resident #177 verified no alternative methods of pain relief were being provided, adding only pain medications have been provided. On 04/15/25 at 2:34 PM Resident #177 was observed in bed requesting an ice pack. Observation on 04/16/25 at 12:50 P.M. of Resident #177 revealed the resident was in bed and reported a pain level of 5 to low back, bilateral hips and lower extremities. Interview with Resident #177 at the time of the observation revealed the resident had not been receiving ice packs between scheduled pain medication to control pain as requested. Continued observation noted disposable ice pack warm to touch at Resident #177 bedside. On 04/16/25 at 12:55 P.M. interview with Certified Nurse Aide (CNA) #551 verified Resident #177 was given an ice pack at 7:00 A.M. CNA #551 confirmed Resident #177 was required to request an ice pack. On 04/16/25 at 1:00 P.M. interview with the Director of Nursing (DON) during review of the medical record for Resident #177 verified the record lacked evidence of ice packs being provided as ordered. In addition, the DON verified no non-pharmacologic intervention related to the application of an ice pack was listed on pain care plan. According to the Pain Management policy revised 10/26/2023. The facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal. If re-assessment findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated. This deficiency represents non-compliance investigated under Complaint Number OH00164044.

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	04/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based observation, staff interview and review of facility policy, the facility failed to ensure adequate infections control practices were carried out. This had the potential to affect the 38 residents (#55, #37, #4, #33, #50, #5, #29, #47, #17, #11, #35, #28, #26, #9, #44, #42, #41, #18, #51, #43, #67, #7, #15, #25, #30, #6, #277, #52, #24, #12, #22, #8, #36, #54, #13, #27, #1, and #49) who resided on the 100 and 200 hallways. The facility census was 73. Findings include: 1. Observation on 04/14/25 at 9:18 A.M. of the 200 hallway found four rooms identified as being on droplet isolation. Personal Protective Equipment (PPE) including gowns, gloves, respirators (N-95s), and a face shields were available for each room on the over the door organizer. Signs with directions for donning personal protective equipment (PPE) were posted on the doors. Observation on 04/14/25 at 9:21 A.M. found Certified Nursing Assistant (CNA) #562 donned a gown, N-95, gloves and face shield and entered room [ROOM NUMBER]. Observation on 04/14/25 at 9:24 A.M. found CNA #562 had removed gown, gloves inside the room and placed the face shield back in the over the door organizer. CNA #562 did not disinfect the face shield after use. Interview on 04/14/25 at 9:25 A.M. with CNA #562 verified the face shields were reused and he had placed the used face shield back in the over door organizer after exiting the room. Observation on 04/14/25 at 9:26 A.M. of CNA #562 found CNA #562 donned a gown, gloves, a N-95, and the face shield from the over the door organizer from room [ROOM NUMBER]. CNA #562 did not disinfect the face shield prior to applying the face shield and entering room [ROOM NUMBER]. Observation on 04/14/25 at 9:29 A.M. of CNA #562 found CNA #562 exited room [ROOM NUMBER] having doffed gown and gloves. CNA #562 removed his face shield and placed it back into the over the door organizer without disinfecting the face shield. Coinciding interview with CNA #562 verified there were bleach wipes available at the nurses station for disinfecting surfaces and had not been used on the face shields. Review of the undated posted signage with the steps for removing personal protective equipment (PPE) revealed in step two of the process it stated the outside of the goggles or face shield were contaminated. If the item was reusable, it was to be placed in designated receptacle for reprocessing, or otherwise discard in the waste container. Review of the facility policy titled, Infection Prevention and Control Program, revised 10/24/22 revealed all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with out current procedure governing the cleaning and sterilization of soiled or contaminated equipment. Single use devices must be discarded after use and are never used for more than one resident. (continued on next page)

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	04/17/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51513 2. Observation on 04/15/25 at 7:48 A.M. revealed Certified Nurse Assistant (CNA) #562 delivered a breakfast tray into room [ROOM NUMBER] without performing hand hygiene. CNA #562 then exited room without performing hand hygiene and proceeded to room [ROOM NUMBER] which was a Covid isolation room. CNA #562 then proceeded to don all required PPE including gown, N-95, face shield, and gloves and entered the Covid isolation room without performing hand hygiene. CNA #562 then delivered a morning breakfast tray into room. Upon exiting the room and removing PPE CNA #562 did not perform hand hygiene and walked down the hall towards nursing station. Interview on 04/15/25 at 7:55 A.M. with CNA #562 confirmed no hand hygiene was performed before or after entering neither room [ROOM NUMBER] or 207. Review of the undated posted signage with the steps for removing PPE revealed that step four is to wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE. Review of policy titled, Hand Hygiene with a revised date of 12/13/2023 revealed that all staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and review of the facility policy, the facility failed to keep the privacy curtain clean in the residents room. This affected one resident (#5) of 24 reviewed for environment. The facility census was 73. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] and an admission diagnosis of dementia. Review of the annual Minimum Data Set (MDS) dated [DATE] for Resident #5 revealed he was cognitively impaired and was dependent for all care. Review of the care plan revised 02/25 for Resident #5 revealed he was care planned for behaviors related to dementia of taking his brief off in bed. Observation on 04/15/25 at 1:28 P.M. revealed Resident #5's privacy curtain had several brown stains that were unidentifiable along the bottom of the privacy curtain approximately one third up the privacy curtain and approximately two feet in length. Interview on 04/15/25 at 1:37 P.M. with Certified Nursing Assistant (CNA) #569 verified the unidentified brown stains on the privacy curtain of Resident #5. Review of the facility policy titled, Routine Cleaning and Disinfection, revised 02/22 revealed privacy curtains in resident rooms will be changed with visibly dirty by laundering or cleaning with registered disinfectant per managers instructions.