STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365674	A. Building B. Wing	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on observation, medical record review, facility policy review and staff interview the facility failed to ensure residents in reclined wheelchairs had physician's orders in place for use and were appropriately assessed to determine appropriate indication for use. This affected one resident (Resident #4) of one resident reviewed for possible physical restraint use. The facility identified no current residents utilizing physical restraints. The facility census was 70. Findings include: Observations of Resident #4 from 03/27/23 to 03/30/23 revealed the resident utilized a reclining tilt in space wheelchair (a wheelchair with a tilt feature permitting the whole chair to tilt 30 to 60 degrees while maintaining knees at a 90 degree angle). Review of Resident #4's medical record revealed an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease, peripheral vascular disease and hypertension. Review of Resident #4's Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 02/27/23 identified no use of any type of physical restraint. The resident had a severely impaired cognition level and required extensive to total assistance with all activities of daily living. Further review of the medical record for Resident #4 found no evidence of any physician's order for use of a reclining tilt in space wheelchair. Review of Resident #4's assessments including the Safety Device Data Collection and Evaluation completed on 03/12/23 identified the only device evaluated was the use of assist grab bars to the bed. No assessment for the use of the reclining tilt in space wheelchair was found. Review of Resident #4's plan of care found no care plan or intervention in place regarding the use of a tilt in space wheelchair. Interview with the Director of Nursing on 03/29/23 at 3:50 P.M. revealed Resident #4 uses the reclined tilt in space wheelchair for comfort and positioning as an enabling device, not a physical restraint. She also verified no physician's order for use of the reclined tilt in space wheelchair or assessment to determine if the device is a restraint or an enabling device. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Restraints with a review/revise date of 01/02/22 revealed restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. An evaluation will be completed to determine the medical symptom requiring the device and to determine the least restrictive device to treat the symptom. Care plans which include the use of the physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used and the time limit for the use of the method.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a behavioral care plan was in place. This affected one (Resident #21) of one resident reviewed for behaviors. The facility census was 70. Findings Include: Review of medical record of Resident #21 revealed an admitted [DATE] and diagnoses included acute and chronic respiratory failure with hypoxia (low blood oxygen), recurrent unspecified major depressive disorder, altered mental status, and cognitive communication deficit. Review of the admission 02/26/23 Minimum Data Set (MDS) assessment revealed Resident #21 was cognitively intact, required supervision of one person for locomotion, limited assistance of one person for walking and dressing, limited assistance of two persons for bed mobility, and extensive assistance of two persons for transfers. Review of the 02/27/23 progress note revealed Resident #21 was very agitated and was shouting and calling staff names. Review of the 03/06/23 progress note revealed Resident #21 was visibly soiled, and when the nurse and state tested nursing assistant (STNA) offered to toilet and clean up Resident #21, he refused and stated, using profanities, he knew when he needed changed. Review of 03/08/23 progress note revealed Resident #21 was demanding with staff and other residents, yelling in room or hallway demanding his requests be fulfilled at that moment, and impatient with staff regarding various things. Review of the 03/13/23 psychiatry note revealed Resident #21 was very irritable, uncooperative, and used profanities. His affect was angry. Review of the 03/14/23 progress note revealed Resident #21 was verbally aggressive, impulsive and was using profanity. Review of the care plan for Resident #21 revealed there was no behavioral care plan. Observation on 03/27/23 around 9:00 A.M. during the screening process, revealed Resident #21 appeared agitated and short tempered when he answered the surveyor's questions. Interview conducted on 03/28/23 at 1:44 P.M. with Social Services #453 confirmed Resident #21 did have behaviors and all behaviors should be in the care plan. Social Services #453 stated not having a behavioral care plan for Resident #21 might have been an oversight. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Behavior Management Program, revised 01/01/22, revealed for residents exhibiting behaviors negatively affecting self or other residents, the Behavioral Management team would explore the root cause of behaviors/mood, would identify target behaviors, and develop an individualized plan of care.

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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** 35765 Based on observation, medical record review, and staff interview, the facility failed to ensure thorough weekly skin assessments were completed on the open area to the right palm of Resident #39. This affected one resident (Resident #39) of two residents reviewed for non-pressure skin condition. Findings included: Review of the medical record revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, persistent vegetative state, COVID-19, cognitive communication deficit, right and left forearm contracture, traumatic brain injury, traumatic subarachnoid hemorrhage, aphasia, epilepsy, pneumonia, deformity of the head, gastrostomy, tracheostomy, and seizures. Review of the physician's orders revealed Resident #39 had an order to cleanse his right palm with normal saline (NS), apply an abdominal dressing, wrap with Kerlix, change daily and as needed dated for 03/20/23. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #39 had severely impaired cognition and required total assist with all activities of daily living. Review of the Pertinent Charting for skin dated 02/01/23 revealed Resident #39 had an open area to the right palm with maceration tissues to surrounding area measuring 0.2 cm in depth and 0.2 circular in size. Intervention was to trim the resident's nails. Review of the weekly Skin Assessments from 02/09/23 to 03/25/23 revealed no measurement or assessment of the open area to the resident's right palm. Observation on 03/28/23 at 10:02 A.M. revealed Licensed Practical Nurse (LPN) #475 opened the hands of Resident #39 and verified the resident's fingernails needed trimmed. At the time of the observation, the open area to the resident's right palm was healed but the area remained reddened. On 03/29/23 at 2:41 P.M. an interview with the Director of Nursing (DON) revealed Resident #39 had an open area to his right hand that was from his fingernail digging in to his hand. The DON verified the lack of skin assessment of Resident #39's open area to his right palm.

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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** 35765 Based on medical record review, observation,and staff interview the facility failed to ensure bilateral hand splints were applied to the hands of a resident. This affected one resident (Resident #39) of three residents reviewed for mobility. Findings included. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, persistent vegetative state, COVID-19, cognitive communication deficit, right and left forearm contracture, traumatic brain injury, traumatic subarachnoid hemorrhage, aphasia, epilepsy, pneumonia, deformity of the head, gastrostomy, tracheostomy, and seizures. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #39 had severely impaired cognition and required total assistance with all activities of daily living. Review of the plan of care dated 05/08/20 revealed Resident #39 needed activities of daily living assistance related to a traumatic brain injury, comatose, and requiring total dependence on staff for all needs. Interventions included to check nail length, trim and clean on bath day as resident would allow and as necessary. Report any changes to the nurse. Review of the physician's orders revealed Resident #39 had an order (dated 03/20/23) to cleanse his right palm with normal saline (NS), apply an abdominal dressing, wrap with Kerlix, change daily and as needed. The resident also had an order (dated 07/29/22) to wear bilateral hand splints following evening care and removed with morning care per the resident's tolerance and to wear a left upper extremity resting hand splint and right upper therapeutic carrot up to eight hours at a time per the resident's tolerance to maintain upper extremity range of motion. Review of the medical record, including the medication administration record, the treatment administration record and Point Click Care Nurse Assistant Task section revealed no documentation of the bilateral hand splints being applied following evening care and removed with morning care. Review of Resident #39's progress notes from 01/01/23 to 03/29/23 revealed no documentation Resident #39 had refused to allow the staff to put his bilateral hand splints on after evening care. Observation on 03/28/23 at 10:02 A.M. revealed Licensed Practical Nurse (LPN) #475 opened the hands of Resident #39. A interview at this time, LPN #475 verified the resident's fingernails needed trimmed. On 03/30/23 at 11:10 A.M. an interview with the Director or Nursing (DON) verified there was no documentation of the bilateral hand splints being applied in the evening and removed in the morning for Resident #39.

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F 0689 Level of Harm - 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** 34298 Based on record review and interview the facility failed to provide adequate assistance, including appropriate lower extremity support during transport of Resident #3 (with hemiparesis/hemiplegia to the right side) in a wheelchair. This affected one resident (Resident #3) of one resident reviewed for a fall with major injury. The facility census was 70. Actual Harm occurred to Resident #3 on 02/20/23 when staff failed to provide adequate lower extremity support to the resident during transport resulting in the resident's leg dragging on the floor and the resident falling from the wheelchair and suffering a right clavicle fracture and proximal humeral fracture. Findings include: Review of the medical record revealed Resident #3 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis (weakness) affecting the right side, type 2 diabetes mellitus, chronic embolism and thrombosis, spinal stenosis, osteoporosis, long term use of anticoagulants, major depressive disorder, anxiety disorder, bipolar disorder, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was cognitively intact and had no behaviors. The assessment revealed Resident #3 required extensive assistance of one staff for bed mobility and transfers. Review of the plan of care dated 12/14/22 revealed Resident #3 was at risk for falls related to weakness, history of cerebrovascular accident, and spinal stenosis. Interventions included to anticipate and meet Resident #3's needs based on nursing assessments and encourage rest periods as needed to avoid overtiring. A new intervention was added on 03/16/23 for bilateral foot rests to be on while Resident #3 was in wheelchair. Review of an initial fall assessment dated [DATE] at 3:15 P.M. revealed Resident #3 was being pushed by staff in wheelchair. Resident #3 had a small goose egg to right side of head and pain to right shoulder and right side of head. Review of Witnessed Fall documentation dated 02/20/23 (no time) revealed Resident #3 stated she could not keep her foot up all the way and it dropped down causing her to be thrown out of the wheelchair. A predisposing psychological factor of weakness and the resident was ambulating with assistance was marked on the form. State tested Nursing Assistant (STNA) #458's statement revealed she was pushing Resident #3 in the wheelchair and the resident's foot dragged on the floor and the resident fell forward. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a nurse's note dated 02/20/23 at 4:10 P.M. revealed the nurse was sitting at the nurse's station and heard a thud and an aide yell for help. Resident #3 was observed on the floor in the hallway lying on right side with her right arm underneath her and her head on the floor. The resident stated she hit her head and landed on her arm. Resident #3 stated she could not keep her foot up and when she dropped her foot down her shoe caught on the floor causing her to fall forward out of the wheelchair. Resident #3 complained of pain with range of motion and had a small goose egg to right side of the head. A nurse note dated 02/20/23 at 9:00 P.M. revealed Resident 3's sister was notified of the fall and increase in right shoulder pain. The resident's sister requested the resident be sent to the hospital for x-rays. Review of discharge instructions from the hospital dated 02/20/23 at 11:04 P.M. revealed Resident #3 had a clavicle injury and needed to follow up with orthopedic in three to five days. Information for fractured clavicle was also included in the discharge instructions. Review of x-ray results dated 02/20/23 at 11:42 P.M. revealed Resident #3 had a comminuted and angulated distal third right clavicle fracture without dislocation. The resident also had a remote proximal humeral fracture with questionable anterior subluxation versus positioning. An order dated 02/21/23 at 2:26 P.M. was received for Resident #3 to have bilateral foot rests on wheelchair during use. Review of a nurse note dated 02/21/23 at 2:45 A.M. revealed Resident #3 returned from the hospital without any new orders. The nurse called the hospital to get the results of the x-ray. The hospital reported Resident #3 had a right clavicle and right humerus fracture. Review of a nurse note dated 02/21/23 at 2:56 P.M. revealed Resident #3 returned from an orthopedic emergency department with new orders for non-weight bearing to right upper extremity and immobilizing splint to right arm. Resident #3 was evaluated by therapy and the resident was to remain one assist for ambulation and transfers. Bilateral leg rests were added to wheelchair for safety until Resident #3 could resume normal activity. Review of a nurse note dated 02/23/23 at 1:11 P.M. revealed Resident #3's sister reported the resident was depressed due to recent fall and requested possible consult with counselor. The nurse spoke with Resident #3 regarding sadness/depression. Resident #3 reported she was upset because she fell and she wanted to go home soon. Interview on 03/27/23 at 10:00 A.M. with Resident #3 revealed (on 02/20/23) she had a shower and staff were taking her back to her room in a wheelchair when she fell . Resident #3 stated she was holding her feet up and her foot fell down and caught the floor and she fell forward out of the wheelchair. Interview on 03/29/23 at 10:54 A.M. the Director of Nursing (DON) verified a staff member was pushing Resident #3 in her wheelchair when the resident fell forward out of the wheelchair. The DON verified there were no foot rests on the resident's wheelchair due to the resident frequently used her feet to propel herself. After the resident fell , an order was received for foot rests to be placed on wheelchair.

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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** 35765 Based on observation, medical record review, staff interview, and facility policy review the facility failed to maintain a sterile field during tracheostomy care for Resident #39. This affected one resident (Resident #39) of one resident reviewed for tracheostomy care and treatment. Findings included: Review of the medical record revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, persistent vegetative state, COVID-19, cognitive communication deficit, right and left forearm contracture, traumatic brain injury, traumatic subarachnoid hemorrhage, aphasia, epilepsy, pneumonia, deformity of the head, gastrostomy, tracheostomy, and seizures. Review of the physician's orders revealed Resident #39 had an order (dated 07/16/22) for tracheostomy care every shift and as needed. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #39 had severely impaired cognition. The resident required total assist with all activities of daily living and had a tracheostomy. Observation on 03/28/23 at 10:06 A.M. of Licensed Practical Nurse (LPN) #475 providing tracheostomy care to Resident #39 revealed she washed her hands and put on a pair of clean gloves from the box of gloves in the room, and placed a barrier down on the over the bed table. LPN #475 unfastened the resident's tracheostomy oxygen mask with her gloved hands then proceeded to open the sterile tracheostomy kit with her nonsterile gloved hands. LPN #475 took the fluid container/box out of the sterile kit and opened it, placed it on the barrier with her nonsterile gloved hands. LPN #475 then opened the nonsterile container of normal saline (not from the sterile kit but one she had brought into the room from the treatment cart) and poured it into the fluid container. She removed the sterile gloves from the kit with her nonsterile gloved hands and placed them on the barrier then took her nonsterile gloves off and went to wash her hands. LPN #475 verified (during interview) at this time she broke the sterile field by touching the items in the sterile tracheostomy kit with her nonsterile gloved hands and threw everything away and started over. Review of the facility policy titled, Tracheostomy Care, dated 10/30/20 revealed the facility would ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. In Step 6 the procedure indicated to open and set up the sterile tracheostomy care kit and apply sterile gloves.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interview, the facility failed to provide ongoing communication with the dialysis center for Resident #7. This affected one resident (Resident #7) of one resident reviewed for dialysis. The facility census was 70. Findings include: Review of the medical record revealed Resident #7 was admitted on [DATE]. Diagnoses included but not limited to end stage renal disease and type 2 diabetes mellitus. Review of the plan of care date dated 02/09/23 revealed Resident #7 required dialysis related to renal failure. Interventions included dialysis on Monday, Wednesday, and Friday, obtain and monitor laboratory/diagnostic work as ordered, and report results to physician and follow up as indicated. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #7 was cognitively intact. Physician orders included dialysis every Monday, Wednesday, and Friday. Review of the medical record for Resident #7 revealed the only dialysis communication was a nutritional profile and pre and post weights dated 03/20/23. Interview on 03/28/23 at 9:12 A.M. with facility Registered Dietician (RD) #480 revealed the facility currently had one dialysis resident, Resident #7. RD #480 contacted the dialysis center to speak with the renal RD when he needed to document on Resident #7. RD #480 revealed he had contacted the dialysis center and left multiple message for a return phone call. RD #480 stated they did speak with someone at the dialysis center and obtained laboratory information. Interview on 03/28/23 at 10:45 A.M. Resident #7 revealed the dialysis center sent paperwork back to the facility with the driver and she was not aware of what information was sent between the facility and the dialysis center. Interview on 03/29/23 at 9:08 A.M. the Director of Nursing (DON) verified the only communication from dialysis was nutritional profile and pre and post weights dated 03/20/23. Interview on 03/29/23 at 9:12 A.M. dialysis Patient Care Technician (PCT) #485 revealed the facility needed to send forms/booklet for the dialysis center for information to be put in to be sent back to the facility. Interview on 03/29/23 at 10:15 A.M. dialysis Administrator #490 revealed Resident #7's current facility did not send a communication book or forms to be filled out and sent back. Administrator #490 stated if there were any changes or problems, the dialysis center would call the facility where Resident #7 resided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interview, the facility failed to ensure Resident #60 had appropriate indications for the use of as needed anti-anxiety medication, and non-pharmalogical interventions were attempted before the as needed anti-anxiety medication was administered. This affected one resident (Resident #60) of five residents reviewed for unnecessary medications. Facility census was 70. Findings include: Review of medical record revealed Resident #60 was admitted on [DATE]. Diagnoses included dementia, major depressive disorder, anxiety, and acute kidney failure. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #60 had cognitive impairment. The MDS also revealed Resident #60 received anti-anxiety medication. Plan of care dated 01/09/23 revealed Resident #60 used anti-anxiety medications related to anxiety disorder. Interventions included to administer medications as ordered and monitor for side effects and effectiveness every shift. Targeted behaviors included obsession over bowel and bladder and fixation on object or person. Review of documentation by State tested Nursing Assistants (STNA) revealed Resident #60 frequently obsessed over bowel and bladder and was fixated on an object or person. Review of physician orders revealed Resident #60 was ordered lorazepam (anti-anxiety) one milligram (mg) every morning and bedtime and lorazepam 0.5 mg every six hours as needed. The medication administration record (MAR) for February 2023 revealed Resident #60 was administered 44 doses of as needed lorazepam 0.5 mg without documentation of behaviors or non-pharmalogical interventions being attempted before medication was administered. The MAR for March 2023 revealed Resident #60 was administered 21 doses of as needed lorazepam 0.5 mg without documentation of behaviors or non-pharmalogical interventions being attempted before medication was administered. Interview on 03/28/23 at 2:50 P.M. Registered Nurse (RN) #405 revealed Resident #60 would sometimes yell out for staff. RN #405 stated Resident #60 had not been having behaviors recently that she was aware of. RN #405 verified there was no documentation of Resident #60 having behaviors in the last 30 days. Interview on 03/29/23 at 9:46 A.M. Director of Nursing (DON) verified there was no documentation of behaviors or non-pharmalogical interventions being attempted before Resident #60 was administered as needed lorazepam in February and March 2023.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, medical record review, and staff interview revealed the facility failed to provide adaptive feeding utensils for Resident #41 at meal time. This affected one resident (Resident #41) of five residents reviewed for nutrition. Findings included: Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, traumatic brain injury, COVID-19, congestive heart failure, chronic kidney disease, muscle weakness, gastroesophageal reflux disease, major depressive disorder, hypothyroidism, generalized anxiety disorder, dysphagia, iron deficiency anemia, hypertension, transient ischemic attack, feeding difficulties, cognitive communication deficit, aphasia, peripheral vascular disease, non-rheumatic mitral valve disorder, and hypomagnesemia. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #41 had moderately impaired cognation, required supervision with eating. Resident #41 had a weight loss and was not on a prescribed weight loss regimen. Review of the physician's orders dated 02/10/23 revealed Resident #41 had an order for curved utensils and a divided plate with meals. Review of the meal ticket dated 03/27/23 revealed Resident #41 was to have a divided plate and right curved utensils. Observation on 03/27/23 at 9:09 A.M. revealed Resident #41 was eating breakfast in her room. She had eaten her cereal, however she had not touched the sausage gravy and biscuits. The resident's meal ticket indicated she was to have curved utensils, however she received regulars silverware from the kitchen on her breakfast tray. On 03/27/23 at 9:10 A.M. an interview with State tested Nursing Assistant #410 verified Resident #41 had not received curved utensils. She indicated the kitchen could not find them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365674	A. Building B. Wing	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, staff interview, and facility policy review the facility failed to notify residents, their representatives and families of a single occurrence COVID-19 in the facility. This affected five residents (Residents #15, #26, #41, #47, and #61) of five residents reviewed for infection control with the potential to affect all 70 residents in the facility. The facility census was 70. Findings included: Review of the facility's COVID-19 positive list for the last four weeks revealed Physical Therapist #505 tested positive on 03/02/23 and Dietary Aide # 403 tested positive on 03/14/23. On 03/30/23 at 11:34 A.M. an interview with Registered Nurse (RN) #420 revealed all families were notified the facility would update the facility website if there was any positive cases of COVID-19 in the facility, RN #420 indicated they did not call families individually unless their family member was affected and positive. RN #420 further indicated the facility residents were not notified unless they were to ask specifically. On 03/30/23 at 12:35 P.M. an interview with Resident #15 revealed the facility used to notify the residents of positive COVID-19 in the facility but not anymore. She indicated she heard through staff gossip. On 03/30/23 at 12:38 P.M. an interview with Family Member #500 revealed the facility used to notify family of positive COVID-19 in the facility but not anymore. He stated he only knows of an outbreak now when he sees the testing cart going around the facility testing the residents. Review of the facility policy titled, COVID-19 Surveillance, dated 10/17/22 revealed the facility would implement heightened surveillance activities for coronavirus illness during periods of transmission in the community and/or during a declared public health emergency for the illness. Residents and representative would be kept up to date on conditions inside the facility related to COVID-19. The minimum information would be reported within 12 hours and subsequently an occurrence of a single confirmed infection of COVID-19 or 3 or more residents or staff with new onset of respiratory symptoms that occur within 72 hours. 1. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included spina bifida, paraplegia, obstructive hyrdrocephalus, edema, obstructive and reflux uropathy, and cervicalgia. Review of the progress notes dated from 03/01/23 to 03/27/23 revealed no documentation Resident #15 was notified of any occurence of COVID-19 positive residents or staff. 2. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included osteoarthritis, COVID-19, gout, cognitive communication deficit, peripheral vascular disease, and dysphagia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365674	A. Building B. Wing	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the progress notes dated from 03/01/23 to 03/27/23 revealed no documentation Resident #26 was notified of any occurence of COVID-19 positive residents or staff. 3. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, traumatic brain injury, COVID-19, congestive heart failure, chronic kidney disease, muscle weakness, gastroesophageal reflux disease, major depressive disorder, hypothyroidism, generalized anxiety disorder, dysphagia, iron deficiency anemia, hypertension, transient ischemic attack, feeding difficulties, cognitive communication deficit, aphasia, peripheral vascular disease, nonrheumatic mitral valve disorder, and hypomagnesemia. Review of the progress notes dated from 03/01/23 to 03/27/23 revealed no documentation Resident #41 was notified of any occurence of COVID-19 positive residents or staff. 4. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE]. Diagnoses included sepsis, metabolic encephalopathy, COVID-19, dementia, atrial fibrillation, hypertension, benign prostatic hyperplasia, pacemaker, repeated falls, pleural effusion and cognitive communication deficit. Review of the progress notes dated from 03/01/23 to 03/27/23 revealed no documentation Resident #47 was notified of any occurence of COVID-19 positive residents or staff. 5. Review of the medical record revealed Resident #61 was admitted to the facility on [DATE]. Diagnoses included congestive heart failure, anxiety disorder, COVID-19, diabetes, pneumonitis, subarachnoid hemorrhage, osteoarthritis, chronic kidney disease, cognitive communication deficit, atrial fibrillation cardiomyopathy, hypertension, acute respiratory failure, aphasia, gout, insomnia, obstructive sleep apnea, and dementia. Review of the progress notes dated from 03/01/23 to 03/27/23 revealed no documentation Resident #61 was notified of any occurence of COVID-19 positive residents or staff.