STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365675	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Milford	5900 Meadowcreek Drive Milford, OH 45150

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of a hospital record, staff interview, review of the facility investigation, and policy review, the facility failed to ensure a resident (#70) was free from neglect when the facility failed to provide appropriate and timely assessment, treatment, service, and notification to the physician or nurse practitioner. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries, and/or death when on [DATE] at 7:46 P.M., Resident #70 was found to have elevated blood glucose levels by a nurse and after notification to the nurse practitioner, additional insulin was ordered, which the resident refused. The nurse did not make notification to the nurse practitioner or physician of the resident's refusal of additional insulin and no additional checks of the resident's blood glucose level were attempted. Resident #70 was later found on the floor, was not answering questions, but was able to move all extremities, and the right side of the resident's face was slightly swollen. Furthermore, the nurse did not complete a neurological assessment of the resident, and no notifications were made to the physician or nurse practitioner of the resident's change in condition. Resident #70 was found later the next morning on [DATE] at 2:42 A.M. with bluish-colored skin tone, abdominal breathing, an extremely edematous head, and was not responding to verbal or physical stimuli. The lack of timely assessments, treatments, services, and notification to the physician or nurse practitioner contributed to Resident #70's untimely death when the resident was taken to the emergency department, was found to have a further elevated blood glucose level, was diagnoses with acute encephalopathy, with multiple metabolic/infectious abnormalities, acute metabolic acidosis, and ultimately died. This affected one (#70) of three residents reviewed for abuse and neglect. The facility census was 72. On [DATE] at 9:03 A.M., Regional Director of Operations #199 and Regional Director of Clinical Operations (RDCO) #595 were notified that Immediate Jeopardy began on [DATE] at 7:46 P.M. when Resident #70's blood glucose level measured 583 milligrams per deciliter (mg/dL) and previous Director of Nursing (DON) #395 notified the nurse practitioner of the elevated blood glucose level. The nurse practitioner ordered additional insulin which the resident refused, and previous DON #395 did not make notification to the nurse practitioner or physician of the resident's refusal of additional insulin and no additional checks of the resident's blood glucose level were attempted or documented in the medical record. Resident #70 was found on the floor on [DATE] at 2:42 A.M. and was not answering questions, but was able to move all extremities, and the right side of the resident's face was slightly swollen. Previous DON #395 did not complete a neurological assessment of the resident, and no notifications were made to the physician or nurse practitioner of the change in condition. On [DATE] at 7:15 A.M., Licensed Practical Nurse (LPN) #155 entered Resident #70's room to check the resident's blood glucose level and administer insulin and found Resident #70 in bed with bluish-colored skin tone, (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
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	abdominal breathing, an extremely edematous head, and the resident was not responding to verbal or physical stimuli. A medical code was initiated by facility and emergency medical services (EMS) arrived at the facility and transported the resident to the hospital. At the hospital, Resident #70 was noted to have a blood glucose level greater than 784 mg/dL and had diagnoses of acute encephalopathy, with multiple metabolic/infectious abnormalities, and acute metabolic acidosis. Resident #70 ultimately died on [DATE]. The Immediate Jeopardy was removed on [DATE] at 4:00 P.M., when the facility sent Resident #70 to the ED for treatment following a change in condition, notification was made to the physician, the facility began an investigation, previous DON #395 was suspended, all residents were assessed for change in condition with all concerns addressed immediately, all staff members were educated, and all medical records were reviewed for change in condition and blood glucose levels with no concerns identified. The deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on [DATE] when the facility implemented the following corrective actions: • On [DATE] at 7:32 A.M., Resident #70 was sent to the ED with notification made to the physician. • On [DATE] beginning at 10:00 A.M., Previous Administrator #495 and Minimum Data Set (MDS) Nurse #146 reviewed the 24-hour report and self-identified a concern with Resident #70's refusal of an order for 16 units of insulin on [DATE] at 7:46 A.M. and failure to notify the physician/nurse practitioner during morning clinical meeting. This concluded at 12:00 P.M. • On [DATE] at 12:00 P.M., Previous Administrator #495 and RDCO #595 obtained statements and conducted interviews with LPN Unit Manager #600, Medication Technician #127, LPN #130, LPN #155, Respiratory Therapist (RT) #82, Certified Nurse Aide (CNA) #605, RT #124, CNA (#610), and previous DON #395. This concluded at 9:00 P.M. • On [DATE] at 2:30 P.M., RDCO #595 was notified by Previous Administrator #495 of the situation that involved Resident #70 and arrived at the facility at approximately 5:00 P.M. to assist with the investigation. • On [DATE] at 8:00 P.M., Registered Nurse (RN)/Staff Development Coordinator (SDC) #375 assessed all residents who had a recent fall and completed a neurological check. There were no residents found with a neurological change in condition. • On [DATE] at 9:00 P.M., LPN #116, LPN #146, RDCO #595, and LPN #600 assessed all residents for a (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	change in condition. There were no residents found with a change in condition. • On [DATE] at 9:30 P.M., Previous Administrator #495 suspended previous DON #395 pending investigation for his failure to notify Nurse Practitioner (NP) #195 of Resident #70's refusal to be administered insulin as ordered by the nurse practitioner and subsequent change in condition. Previous DON #395 was terminated from employment on [DATE]. • On [DATE], RN/SDC #375 provided all nurses, medication technicians, and CNAs with education related to fall assessment protocols, notification of physicians for resident change of condition, the importance of initiating treatment, the importance of rounding every two hours, the importance of obtaining neurological checks when it was suspected the resident had a head injury and/or was on blood thinners, and the importance of initiating the risk management application in the electronic medical record. All staff were educated by [DATE]. • On [DATE] at 10:00 A.M., RDCO #595 and previous Administrator #495 notified facility Medical Director #995 of the incident and reviewed the policy and procedure for change in condition/notification of change. There were no revisions made to the policy. The root cause analysis identified failure to follow facility policy for notification to a physician by previous DON #395 as the primary cause for Resident #70's deteriorating change in condition. • On [DATE] at 10:00 A.M., a Quality Assurance and Performance Improvement (QAPI) meeting was held with previous Administrator #495, RDCO #595, and Medical Director #995. The policy for change in condition/physician notification was reviewed with no recommended revisions. The result of the facility's root cause analysis (RCA) was reviewed and the staff completed education was reviewed. • On [DATE] at 10:00 A.M., RN #122, LPN #155, and LPN #800 completed walking rounds for resident change in condition. One resident was found with a change in condition, and it was addressed immediately. • On [DATE] at 12:00 P.M., RDCO #595 reviewed all resident blood sugars to ensure notification of variances was made to the physician. There were no variances noted and was completed by 4:00 P.M. • Beginning on [DATE], RDCO #595/designee provided education on resident change in condition and notification to the physician/nurse practitioner to all newly hired nurses and CNAs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• Beginning on [DATE], RDCO #595/designee conducted a daily clinical meeting Monday through Friday, excluding holidays, to review residents with a change in condition and/or transfer to the hospital to ensure proper physician notification was made timely. The clinical meetings continue indefinitely with no concerns identified through the review period. • Beginning on [DATE], RDCO #595/designee monitored the results of the daily clinical meeting for residents with a change in condition and notification to the physician and submitted the findings to the QAPI committee for review and recommendations. This continued monthly with QAPI meetings held on [DATE] and [DATE] and then as needed. There were no concerns noted in the QAPI meeting minutes. • On [DATE], two (#1 and #19) additional resident medical records were reviewed for abuse and neglect with no concerns identified. • Interviews on [DATE] from 9:35 A.M. to 10:05 A.M. with RN #98, RN #122, CNA #96, CNA #80, CNA #119, CNA #127, CNA #99, CNA #105, and CNA #144 verified they received education from the facility regarding a resident change in condition or mental status change from the resident's baseline. CNAs interviewed verified they would immediately notify the nurse of the change in condition and nurses interviewed indicated the physician would be notified immediately. All staff members were able to recall the training and demonstrated proficiency of the education provided. Findings include: Review of the medical record revealed Resident #70 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, tracheostomy, end-stage renal disease (ESRD) with dependence on hemodialysis, diabetes mellitus Type I, hypertension, chronic obstructive pulmonary disease, and chronic viral Hepatitis C. Review of the Minimum Data Set (MDS) Discharge-return not anticipated assessment dated [DATE] revealed Resident #70 had no cognitive deficit and was always continent of bowel and occasionally incontinent of urine. The resident required set up assistance for eating, oral and personal hygiene, toileting and transfers, moderate assistance for bathing, supervision for dressing, and was independent with bed mobility. Review of physician orders revealed Resident #70 had an order dated [DATE] to be administered the anticoagulant medication Eliquis 2.5 milligrams (mg) by mouth with instructions to give one tablet every morning and at bedtime. Review of a fall risk evaluation dated [DATE] revealed Resident #70 was a low risk for falls. Review of physician orders revealed an order dated [DATE] for Resident #70 to be administered aspart insulin with niacinamide 100 units per milliliter per sliding scale subcutaneously (SQ) before (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	meals related to diabetes mellitus Type I. The sliding scale was as follows: for blood glucose levels between zero (0) and 59 mg/dL, implement hypoglycemia protocol; for blood glucose levels between 60 and 150 mg/dL, give 0 units; for blood glucose levels between 151 and 200 mg/dL, give two (2) units; for blood glucose levels between 201 and 250 mg/dL, give four (4) units; for blood glucose levels between 251 and 300 mg/dL, give six (6) units; for blood glucose levels between 301 and 350 mg/dL, give eight (8) units; for blood glucose levels between 351 and 400 mg/dL, give 10 units; for blood glucose levels between 401 and 450, give 12 units; and for blood glucose levels greater than 451 mg/dL, notify the physician. Review of Resident #70's [DATE] medication administration record (MAR) revealed Resident #70 refused aspart insulin with niacinamide 100 units per milliliter as per sliding scale SQ before meals related to diabetes mellitus type I doses on [DATE] at 11:00 A.M. when the blood glucose levels was 170 mg/dL and at 4:00 P.M. when blood sugar level was 400 mg/dL, on [DATE] at 7:00 A.M. when the blood glucose level was 465 mg/dL and at 4:00 P.M. when blood glucose level was 450 mg/dL, on [DATE] at 11:00 A.M. when the blood glucose level was 220 mg/dL, and on [DATE] at 11:00 A.M. when the blood glucose level was 587 mg/dL. Review of a nursing progress note dated [DATE] at 7:46 P.M., written by Licensed Practical Nurse (LPN) #150, revealed Resident #70's glucose reading was 583 mg/dL. The nurse practitioner was notified, and an order was received to administer 16 units of insulin which Resident #70 refused. The resident had a history of non-compliance with the medication regimen. The resident was educated on the risks, up to and including death, of refusing physician orders. The resident was alert and oriented and repeated back understanding of the risks. Review of a nursing progress note dated [DATE] at 2:42 A.M., written by previous DON #395, revealed Resident #70 was found on the floor by a certified nurse aide. The resident was not answering questions but was able to move all extremities. The right side of the resident's face was slightly swollen. A neurologic examination was unable to be completed due to the resident not opening her eyes upon command. Review of a nursing progress note dated [DATE] at 2:43 A.M., written by previous DON #395, revealed Resident #70 was assessed and the resident continued to move all extremities and her bilateral lower extremities which were over the side of the bed. The resident's respirations were easy yet unlabored and the resident continued to not follow commands. Review of a nursing progress note dated [DATE] at 7:15 A.M., written by LPN #155, revealed LPN #155 entered Resident #70's room to administer morning medications and obtain a fingerstick to check the resident's blood sugar and found the resident laying sideways across the bed with her legs dangling off the bed. The resident was noted with a bluish-colored skin tone and abdominal breathing. The resident's head was extremely edematous. The resident's cool air mist tubing was laying on her chest and not connected to the tracheostomy. A thick brown and blood-tinged sputum was noted in and around the tracheostomy. Resident #70 was unresponsive to verbal stimuli and sternal rub. LPN #155 called an emergency medical code at that time and two respiratory therapists immediately responded and initiated suctioning and providing breaths to the resident via a resuscitation (Ambu) bag. The resident's oxygen saturation was 94 percent (%) on the tracheostomy, the heart rate was 144 beats per minute, and the blood pressure could not be obtained. The respiratory therapists continued to provide respirations to Resident #70. At 7:24 A.M., emergency medical transport (EMT) personnel arrived on the scene and care was transitioned to them. At 7:27 A.M., EMT personnel remained on the scene providing first aid to the resident who continued to be unresponsive and with abdominal breathing. The (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident's skin tone returned to a natural color. At 7:32 A.M., EMT personnel transported the resident from the facility to the hospital. A report was called to the receiving hospital emergency department (ED) and notifications were made to the physician and the resident's family. At 12:52 P.M., the resident was admitted to the hospital with a diagnosis of acute metabolic encephalopathy. Review of hospital documents dated [DATE] at 1:09 P.M. revealed Resident #70 had a blood glucose level greater than 784 mg/dL and was admitted unresponsive on mechanical ventilation to the medical intensive care unit (MICU) with a concern for volume overload and flash pulmonary edema. The resident's temperature was 102.6 degrees Fahrenheit. The physician noted the resident was critically ill due to acute encephalopathy and comatose state and if untreated, there was a high risk of imminent or life-threatening deterioration of the resident's condition due to worsening hypoxic-ischemic brain injury, cerebral edema, seizures, brain compression and brain death. Further review of the hospital document revealed on [DATE] at 2:11 P.M., Resident #70 was also assigned a diagnosis of acute metabolic acidosis. Review of a nursing progress note dated [DATE] revealed the family reported Resident #70 expired in the hospital today. Interview on [DATE] at 12:41 P.M. with RN #390 verified there was no documentation that indicated neurological checks were performed on Resident #70 from the time she was found on the floor at [DATE] at 2:42 A.M. until she was transported to the hospital on [DATE] at 7:32 A.M. by EMT personnel or that the physician was notified of the resident's change in condition until transport to the hospital on [DATE] at 7:32 A.M. Telephone interview on [DATE] at 1:12 P.M. with previous DON #395 verified neurological checks were not performed on Resident #70 after finding her on the floor on [DATE] at 2:42 A.M. through the time she was transported to the hospital on [DATE] at 7:32 A.M. Previous DON #395 also verified neither the physician, physician extender, nor family were notified of the resident's change in condition until after the resident was transported to the hospital. He was unable to provide rationale as to why neither neurological checks were obtained nor why the physician and family were not notified. Telephone interview on [DATE] at 8:32 A.M. with NP #195 verified it was the expectation for the facility to make immediate notification to the physician or physician extender for any resident who was experiencing or who had experienced a change in condition. NP #195 verified the facility did not make notification for Resident #70's change in condition until the resident was transported to the hospital on [DATE] at 7:32 A.M. NP #195 stated she should have been called immediately after the resident was found on the floor on [DATE] at 2:42 A.M., especially when it was noted the resident had swelling noted to the face and was on an anticoagulant medication. Interview on [DATE] at 8:40 A.M. with the current DON revealed the findings of the facility's investigation were inconclusive as to how Resident #70 became to be on the floor in the early morning hours of [DATE]. The DON stated Resident #70 had a blanket on the floor and her oxygen tubing remained connected to her tracheostomy. The DON stated it was a strong possibility the resident placed herself on the floor and laid down. The DON did verify neurological checks were not completed on Resident #70 nor was the physician notified of the resident's change in condition until after transport to the hospital on [DATE] at 7:32 A.M. Interview on [DATE] at 11:55 P.M. with NP #195 verified Resident #70 had a history of erratic blood glucose levels and stated the resident was afraid of being administered greater than 8 units of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	insulin for fear of it stacking up due to her diagnosis of type I diabetes mellitus. NP #195 verified the facility, and specifically previous DON #395, should have notified her immediately of the resident refusing the order for the 16 units of insulin on [DATE] at 7:46 P.M. and the resident should have been reassessed between [DATE] at 7:46 P.M. and [DATE] at 2:42 A.M. with an update provided. NP #195 also verified she would have definitely ordered the resident be sent to the hospital on [DATE] at 2:42 A.M. had she been notified by previous DON #395. Review of the policy titled, Abuse, Neglect, and Exploitation, revised [DATE], revealed it was the policy for the facility to provide protections for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Neglect was defined in the policy as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will develop and implement written policies and procedures that: prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. This deficiency represents non-compliance investigated under Complaint Number OH00162132.

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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** Based on observation, staff interview, and medical record review, the facility failed to ensure fall interventions were implemented as care planned. This affected one (#55) of five residents reviewed for falls. The facility census was 72. Findings Include: Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, epilepsy, type II diabetes, major depressive disorder, and stage III chronic kidney disease. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had moderately impaired cognition, had no behaviors, did not wander, and did not reject care. Review of care plan dated 04/29/24 revealed Resident # 55 was at risk for falls related to generalized weakness, poor balance, decreased strength and endurance, and need for assistance with activities of daily living (ADLs). Interventions included to encourage to rest in the afternoon, encourage to lay in the center of the bed, frequently monitor for infection, grab bars to the bed for repositioning, educate on safety interventions, encourage to use the call light, fall mats on floor to bilateral sides of bed, perimeter mattress, observe and report changes in activity levels, call light within reach, encourage the resident to be in common areas when awake, therapy screens as needed, and provide visual cues to assist with transfers. Observation on 03/12/25 at 10:39 A.M. revealed Resident #55 had only one fall mat on floor located on the resident's right side of the bed. There were no other fall mats visible in the room, closet, or bathroom. Observation on 03/12/25 at 3:09 P.M. revealed Resident #55 had only one fall mat on floor located on the resident's right side of bed. There were no other fall mats visible in the room, closet, or bathroom. During an interview on 03/12/25 at 2:09 P.M. Registered Nurse (RN) #98 verified Resident #55 only had one mat on the floor in his room. RN #98 verified there were no other fall mats stored in the room and Resident #55 was care-planned for two fall mats. This deficiency represents non-compliance identified under Complaint Number OH00162508.

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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** Based on medical record review, observation, and staff interview, the facility failed to maintain a safe and clean environment. This affected three (#12, #14, and #46) of 12 residents reviewed for environment. The facility census was 72. Findings include: 1. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, congestive heart failure, hypertension, diabetes mellitus type II, and dementia. Observation on 03/10/24 at 10:15 A.M. revealed Resident #46's room had an area of the wall located below heating ventilation and air conditioning (HVAC) unit that was unpainted drywall was stained with a black substance. 2. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses of cerebrovascular accident with right (dominant) side hemiplegia and hemiparesis, chronic obstructive pulmonary disease, diabetes mellitus type II, morbid obesity, alcoholic cirrhosis, and congestive heart failure. Observation on 03/10/25 at 9:38 A.M. revealed Resident #14's room had a hole in the wall to the right of the television that measured approximately seven inches long and three inches wide at the widest point. Observation and interview on 03/12/25 from 9:30 A.M. to 9:37 A.M. with Maintenance Director (MD) #103 verified the area of Resident #46's wall below the HVAC unit which was unpainted drywall with a black substance on it and verified the hole in the wall to the right of Resident #14's television. 3. Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease with exacerbation, and contracture of the left hand. Observation of Resident #12's room on 03/10/25 at 11:31 A.M. revealed a hole in the wall behind the door that had a towel in the hole. Interview on 03/10/25 at 11:32 A.M. with the Assistant Director of Nursing (ADON) verified there was a towel stuffed in the hole in the wall behind Resident #12's door. This deficiency represents non-compliance investigated under Complaint Number OH00162132.