STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 - Actual harm 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 NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, review of a self-reported incident (SRI), review of facility investigative documentation, review of facility video footage, personnel file review, policy review, and interview the facility failed to protect Resident #70's right to be free from abuse by Certified Nursing Assistants (CNAs) #210, #220 and #225. Actual harm occurred on 04/11/26 when Resident #2, who was cognitively impaired and diagnosed with dementia, was physically and psychosocially abused by CNAs #210, #220, and #225. The three CNAs forced the resident into a chair, held his arms down to keep him seated, and were overheard by other residents teasing and laughing at him. A reasonable person in the resident's position would have experienced fear, distress, humiliation, and a loss of dignity as a result of this treatment. Following the incident, Resident #2 was noted to have bruising and a skin tear to his arms (of unknown origin), increased agitation, which was exacerbated by the staff involved, and he was subsequently ordered and administered the anticonvulsant medication Depakote for two days following the incident for behavioral management. This affected one resident (#2) of the five residents reviewed for abuse.Findings include: Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including vascular dementia, unspecified psychosis, depression, seizure disorder, cognitive communication deficit, unsteadiness on feet, and muscle weakness. Review of Resident #2's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing and clear speech. The assessment revealed the resident was sometimes able to make himself understood and was sometimes able to understand others. The resident's cognition was severely impaired. Physical and verbal behaviors directed at others occurred one to three days during the seven-day assessment period. Other behaviors not directed at others occurred four to six days during the seven-day assessment period. The assessment revealed the resident was not known to reject care but was known to display wandering behavior. No mobility devices were used for his mobility. The resident was assessed to require supervision or touching assistance with sit-to-stand transfers and ambulation.Review of a self-reported incident tracking number 273236, submitted by the facility to the State Agency, revealed an allegation of physical abuse. The initial source of the allegation was identified as an unusual circumstance. Resident #2 was identified as the involved resident and the alleged perpetrator was identified as being facility staff. Resident #2 could not provide any meaningful information when interviewed related to his diagnoses of vascular dementia and cognitive communication deficit. A brief description of the allegation revealed the facility's Administrator was made aware of an allegation of physical abuse by CNAs holding Resident #2's arms down. The CNAs were suspended pending the investigation findings. A narrative summary of the incident revealed the occurrence was on 04/11/26 at 9:30 P.M. at the nurses' station. Residents #17 and #83 were listed as being witnesses to the alleged incident. Staff witnesses were CNA #210, CNA #220, and CNA #225. Witness statements obtained from the staff involved revealed they claimed they were holding the resident's arms due to him being combative (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
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 - Actual harm Residents Affected - Few	towards staff. Resident #2 had an increase in behaviors occurring on 04/11/26. The facility's Administrator filed an official report with the local police department on 04/13/26. The three CNA's involved in the physical abuse allegation involving Resident #2 were terminated from their employment with the facility on 04/20/26, as the facility substantiated the incident of physical abuse had occurred. Review of Resident #2's progress note dated 04/11/26 at 9:30 P.M. and written by Registered Nurse (RN) #200 documented during a medication administration pass, the nurse heard yelling and arguing coming from a female resident's room (Resident #29). Upon the nurse entering the room, she found Resident #2 standing by the female resident's bed where she had been sleeping. Both residents were engaged in a physical altercation where they were hitting and smacking each other. Resident #2 was yelling at the female resident (Resident #29) to get out of his bed. The note revealed the nurse attempted to separate the residents and diffuse the situation. A CNA (unidentified) took Resident #2 up to the nurses' station, where it was documented the resident continued to be physically abusive and verbally aggressive toward staff. Assessments of both residents were performed with no injuries noted at the time. The physician was made aware of the incident and new orders were received for the medications Haldol and Depakote. Resident #2's son was also notified of the altercation and consented to the medication administration that had just been ordered. Resident #2 was later taken to his bed where he eventually fell asleep, so the ordered medication (Haldol) was not given. However, the order for the change in his daily medication (added Depakote) was entered into the computer. The note included the unit manager, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were all notified. Review of the April 2026 Medication Administration Record (MAR) revealed the resident received the ordered Depakote on 04/12/26 and 04/13/26 before it was discontinued by the physician. Review of the facility's investigation file documented there was alleged abuse of a resident status post resident to resident altercation involving Resident #2 and Resident #29. Staff were holding the arms of a resident (Resident #2), walking (Resident #2) down the hallway, and appeared to sit the resident down on a chair forcefully. The CNAs further held the resident's arms down, holding him in the chair. The resident could not provide information or a description of the incident due to his impaired cognition when interviewed by staff.Included in the facility investigation was information from Resident #83 (who was alert and oriented/cognitively intact) obtained by SSD #245 on 04/13/26. Resident #83 stated two girls held an older guy (Resident #2) down in a chair at the nurse's station. All he wanted was to go to his room, while they were holding both of his arms, teasing him. The older guy was not even fighting, and she was not sure what their issue was. Resident #83 told SSD #245 that what she observed was abuse for sure. Included in the facility investigation was information obtained from Resident #17 (who was alert and oriented/cognitively intact) by SSD #245 on 04/13/26. Resident #17 revealed he had observed an incident on 04/11/26. Resident #17 told SSD #245 that two girls (unidentified) held Resident #2 down in a chair and would not let him up. They were laughing and teasing him while holding him down and all the resident wanted to do was walk and get away from everyone. A verbal statement obtained by the Administrator from CNA #260 on 04/13/26 revealed an aide came to the second floor and said they needed help with an altercation between two residents. When they went up there, everyone was standing, trying to figure out things. Resident #2 started to walk, pacing in the dining room. The girls were all up in Resident #2's face, trying to get him to calm down. She (the CNA) did not like how they handled it. When asked if that resident was your family member, would you consider that abuse, the CNA replied yes. A verbal statement obtained by the Administrator from CNA #275 on 04/13/26 revealed her and two other employees were all outside smoking, when the trainee told them someone was on the floor. CNA #210 and CNA #220 were taking Resident #2 up front. She went to get LPN #250 because she was the supervisor. Resident #2 was sitting in the chair and CNA #210 and CNA #220 were holding his arms down. Review of Resident #2's progress note documented he was seen by his attending physician on 04/14/26, as a follow up visit. It was reported to the physician Resident #2 was having an increase in a series of behaviors, with agitation and aggressive behaviors with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 - Actual harm Residents Affected - Few	psychotic issues present. Resident #2 started on Depakote in response to the incident (on 04/11/26). The note included it was found the resident was being treated inappropriately and behaviors were instigated by staff. The physician discontinued the Depakote that had been ordered as the resident had been having increased behaviors before restarting his Seroquel, which had shown marked improvement of his symptoms. Resident #2 was found to be pleasant and cooperative during the visit with the physician on this date. Review of the personnel files for CNA #210, CNA #220, and CNA #225 revealed all three CNAs were terminated from working at the facility on 04/20/26. The reason for termination was violating the rights of the residents, including abuse and for failing to report to their supervisor. During an interview on 04/27/26 at 12:40 P.M., Physician #400 stated he had been told by the facility that Resident #2 was having severe behaviors and was not easily redirected. He was also told the resident was a threat to other residents that prompted him to initiate new medication for the resident. However, he stated Resident #2 was responding to how the staff were intervening with his behaviors. He described the resident as being in a protective type of mode. He was told one of the CNAs grabbed the resident. The new medication had since been stopped and Resident #2 was doing fine without it. Physician #400 revealed staff should have tried to redirect Resident #2 without force, placing the resident in a calm environment and removing him from the provoking area, or getting him away from the situation would also be helpful. If the resident that was being combative was not harmful to himself or others, staff could just walk away and give the resident his space. They could also try to offer them food or drinks to try to alter the behavior. He stated trying to hold down a cognitively impaired resident who was being combative would elicit a retaliatory response from the resident. On 04/27/26 at 1:30 P.M. the video footage of the abuse incident was reviewed with the Administrator. On 04/11/26 at 9:32 P.M., CNA #210 and CNA #220 had Resident #2 by both his arms directing him down the hall towards the nurse's station. He was coming from the long hall on the third floor. The Administrator identified the employee grabbing the resident's right arm as CNA #210 and the employee grabbing the resident's left arm as CNA #220. A third aide, identified as CNA #225, approached around the time the two aides and the resident reached the area by the nurses' station. CNA #210 and #220 initially sat Resident #2 down into the chair. It appeared the staff were exchanging words with Resident #2 but there was no audio on the footage. Resident #2 became agitated a short time after he was initially placed in the chair and he stood up and started heading in the direction of the two CNAs. CNA #225 came back into view of the camera and assisted the two aides with getting the resident back down into the chair. CNA #210 and CNA #220 grabbed the resident by the arms and CNA #225 grabbed the back of Resident #2's sweatpants, pulling them up and back as the resident was forcefully placed in a seated position in the chair. CNA #210 and CNA #220 held Resident #2's arms down, pushing them down against the arm rest of the stationary chair, so he could not get up. CNA #220 was straddling the resident's left leg. CNA #225 left briefly while the two CNAs continued to hold the resident's arms down onto the arm rest of the chair. Their hands were over his wrists and lower forearms in a palm down position with their hands closed. CNA #225 took the place of CNA #210, holding the resident's right arm down onto the arm rest of the chair. She held his arm in the same manner before releasing his arm and holding his hand in her right hand as she supported the weight of his arm in her left hand, when another resident and her visiting family approached and came into view of the camera at 9:35 P.M. Multiple other unidentified staff entered the area along with the nurse assigned to the third floor. There were four staff members who had come up the stairs from the second floor to assist the staff with Resident #2's behaviors. At one point during the video, there were nine staff members, two other residents, and three family members standing in the area in close proximity to Resident #2. Resident #2's right arm was released at 9:36 P.M. CNA #275 replaced CNA #220 with holding the resident's left arm. She was gentler with the resident as she was just holding his hand. The incident concluded at 9:39 P.M. when Resident #2 stood up and started to walk back the long hall. Resident #2 walked around the nurses' station to the dining area before he was allowed to go back down the hall, where the staff helped him get into his (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 - Actual harm Residents Affected - Few	bed. During an interview on 04/27/26 at 3:55 P.M., Resident #83 stated she witnessed the incident on 04/11/26 involving Resident #2 but was not able to identify the staff involved. She stated she came out to the nurses' station area from her hall with some of her family members who were leaving after a visit. She observed the staff holding Resident #2 down, when he was sitting in a chair across from the nurses' station. The resident reported the staff would not allow him to get up out of the chair. She stated staff were laughing at him, telling him they were not going to deal with it that night, and told him, try it again and see what happens and we're holding you down, that means you don't move stupid. During an interview on 04/28/26 at 10:05 A.M., Resident #17 stated he witnessed part of the incident that occurred on 04/11/26 involving Resident #2 and the staff. He recalled the staff were trying to keep Resident #2 sitting down, as he believed it was to keep the resident from falling. The resident stated the staff kept pushing him (Resident #2) down into the chair and would not allow him to get up.During an interview on 04/28/26 at 10:32 A.M., Resident #2's responsible party stated he was contacted by the facility staff on 04/11/26 and informed Resident #2 was wandering and looking into other residents' rooms. He was also told the resident went into one room and tried to get into bed with a female resident that ended up in an altercation. He was informed about a sedative they were wanting to give the resident that evening. He then received a second call on 04/13/26 from the facility's social worker, who went into more detail as to what took place on 04/11/26. He recalled being told the staff were unprofessional in what they did. He was also told the facility management staff looked at video footage and staff were unprofessional about how they handled it. No one told him Resident #2 was abused. He said the director stated she requested to see the film and was disgusted by what she saw. He was told the resident was brought to the nurses' station forcibly and those involved seemed aggravated. During the interview Resident #2's responsible party revealed the facility had contacted the police department regarding the incident. During an interview on 04/28/26 at 1:44 P.M., Regional Director of Clinical Operations #500 and the DON revealed they were reviewing video to follow up on an incident involving a resident-to-resident altercation. It was during this review (on 04/13/26) they saw on the video that abuse had potentially occurred with Resident #2, by staff, during the aftermath of that incident with the other resident. They suspended the CNA staff involved immediately, pending an investigation. They confirmed their investigation did substantiate physical abuse had occurred and the three CNA staff involved in the incident were terminated. Review of the facility Abuse policy revised 01/10/24 revealed it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Abuse meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which could include staff to resident abuse. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse included, but was not limited to hitting, slapping, punching, biting, and kicking. It also included controlling behavior through corporal punishment. The deficient practice was corrected on 04/20/26 when the facility implemented the following corrective actions: On 04/13/26 at 10:00 A.M., the facility self-identified that a potential physical abuse incident had occurred (involving Resident #2), when reviewing a video recording at the third floor nurses' station to follow up on a report of a resident-to-resident altercation. An immediate investigation into the possible abuse was initiated. On 04/13/26 at 10:10 A.M., the facility nurse practitioner was made aware of the allegation of abuse and discontinued an order for Depakote and a Haldol injection that were previously ordered for Resident #2 on 04/11/26. The Haldol IM injection had not been given.On 04/13/26 at 10:15 A.M., a facility floor nurse assessed Resident #2's skin from head to toe and found a skin tear and a small bruise on the resident. At the time of the incident, the facility was unable to determine the origin of the bruise and skin tear. On 04/13/26 at 10:30 A.M. all staff were assigned re-education/ in-service training on Preventing Resident Abuse that was to be completed by 04/15/26. The training was assigned to all staff's in-service training to be completed in SNF Clinic (computer software program used for training (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 - Actual harm Residents Affected - Few	purposes).On 04/13/26 (between 10:30 A.M. and 6:00 P.M.), whole house skin sweeps were completed on all residents with cognitive impairment with no signs or symptoms of abuse noted. All alert and oriented residents were interviewed regarding abuse, with two complaints related to Resident #2's incident. Witness statements were obtained from those residents and from staff involved.On 04/13/26 at 11:00 A.M., PHQ9 and psychosocial assessments were completed on Resident #2. On 04/13/26 at 12:00 P.M., employee questionnaires were initiated for all staff to ensure competency weekly for four weeks and would run plan through the facility Quality Assessment and Performance Improvement (QAPI) committee monthly for two months with the Medical Director's involvement. On 04/13/26 at 1:00 P.M., the alleged perpetrators (CAN #210, #220 and #225) were suspended and statements regarding the incidents were obtained. On 04/13/26 at 5:00 P.M., Resident #2's representative was notified regarding the allegation of physical abuse. On 04/13/26 at 5:30 P.M., incident of alleged abuse was reported to local law enforcement. Local law enforcement to come out on 04/14/26 and took an official report from the Administrator. On 04/13/26 at 6:30 P.M., an Ad Hoc (not scheduled) Quality Assurance, Performance Improvement meeting with the Medical Director, DON, and Administrator was completed to ensure facility compliance with abuse policy and timely reporting of abuse with Quality Plan to ensure all staff were educated on the abuse policy and timely reporting. On 04/14/26 at 8:00 A.M., the Psychiatric Nurse Practitioner (NP) evaluated Resident #2. On 04/14/26 at 2:30 P.M., the (medical) physician evaluated Resident #2. On 04/14/26 at 3:00 P.M., the facility filed an official report with local police department. On 04/20/26 CNA #210, CNA #220, and CNA #225 were terminated due to substantiated abuse. This deficiency represents non-compliance investigated under Incident Number 299063.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and interview the facility failed to ensure Resident #2, who had a diagnosis of dementia with behaviors received adequate, necessary and effective interventions as per his care plan to de-escalate a behavioral episode and to prevent increased agitation for the resident. This affected one resident (#2) of five residents reviewed for abuse. Findings include: Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including vascular dementia, unspecified psychosis, depression, seizure disorder, cognitive communication deficit, unsteadiness on feet, and muscle weakness. Record review revealed a plan of care dated 03/13/26 for behaviors related to dementia, psychosis, depression, and insomnia as evidenced by restlessness, anxiousness/ nervousness, physical aggression, hallucinations, delusions, exit seeking, history of verbal aggression, and wandering. Interventions included administer medications as ordered and observe for effectiveness and side effects, approach resident in a calm manner to avoid frustration and behavior escalation, if resident becomes agitated and shows signs of escalation -re-approach later, attempt to redirect resident when exhibiting behaviors, re-approach when resident has de-escalated, communicate care to resident before starting task, give non-judgmental support, keep resident safe during episodes of behaviors, attempt to redirect, observe and document episodes of inappropriate behaviors, notify physician when behaviors persist and did not de-escalate, offer psychologist/ psychiatrist services as needed, offer resident choices whenever possible in order to promote a feeling of self-worth and control over the environment and care delivery, encourage participation from resident to make own decisions, and offer and provide activities of interest to keep resident engaged in positive interactions. Review of Resident #2's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing and clear speech. The resident was sometimes able to make himself understood and was sometimes able to understand others. The assessment revealed the resident's cognition was severely impaired. Review of Resident #2's progress notes dated 04/11/26 at 9:30 P.M. and written by Registered Nurse (RN) #200 documented during a medication administration pass, the nurse heard yelling and arguing coming from a female resident's room (Resident #29). Upon the nurse entering the room, she found Resident #2 standing by the female resident's bed where she had been sleeping. Both residents were engaged in a physical altercation where they were hitting and smacking each other. Resident #2 was yelling at the female resident (Resident #29) to get out of his bed. The note included the nurse attempted to separate the residents and diffuse the situation. A CNA (unidentified) took Resident #2 up to the nurses' station, where he continued to be physically abusive and verbally aggressive toward staff. The physician was made aware of the incident and new orders were received for Haldol and Depakote. Resident #2's son was also notified of the altercation and consented to the medication administration that had just been ordered. Resident #2 was later taken to his bed where he eventually fell asleep, so the ordered medication (Haldol) was not given. However, the order for the change in his daily medication (added Depakote) was entered into the computer. The unit manager, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were all notified. Review of the nursing progress note revealed no additional information related to how the nurse or staff attempted to diffuse the situation and/or any additional non-pharmacological interventions provided to Resident #2 following and/or as a result of this incident. Review of the April 2026 Medication Administration Record (MAR) revealed the resident received the ordered Depakote on 04/12/26 and 04/13/26 before it was discontinued by the physician. Review of Resident #2's progress note documented he was seen by his attending physician on 04/14/26, as a follow up visit. It was reported to the physician Resident #2 was having an increase in a series of behaviors, with agitation and aggressive behaviors with psychotic issues present. Resident #2 started on Depakote in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	response to the incident (on 04/11/26). The note included it was found the resident was being treated inappropriately and behaviors were instigated by staff. The physician discontinued the Depakote that had been ordered, as the resident had been having increased behaviors before restarting his Seroquel (resumed prior to this incident), which had shown marked improvement of his symptoms. Resident #2 was found to be pleasant and cooperative during the visit with the physician on this date. During an interview on 04/27/26 at 12:40 P.M., Physician #400 stated he had been told by the facility that Resident #2 was having severe behaviors and was not easily redirected. He was also told the resident was a threat to other residents that prompted him to initiate new medication for the resident. However, he stated Resident #2 was responding to how the staff were intervening with his behaviors. He described the resident as being in a protective type of mode. He was told one of the CNAs grabbed the resident. The new medication had since been stopped and Resident #2 was doing fine without it. Physician #400 revealed staff should have tried to redirect Resident #2 without force, placing the resident in a calm environment and removing him from the provoking area, or getting him away from the situation would also be helpful. If the resident that was being combative was not harmful to himself or others, staff could just walk away and give the resident his space. They could also try to offer them food or drinks to try to alter the behavior. He stated trying to hold down a cognitively impaired resident who was being combative would elicit a retaliatory response from the resident. During an interview on 04/28/26 at 12:45 P.M., CNA #225 stated she was working on the short hall of the third floor on 04/11/26 and was outside when an orientee came out and informed them that they needed help. She recalled being told Resident #2 pulled another resident out of bed and they were fighting. By the time she got there, CNAs #210 and #220 were already removing Resident #2 from the room. Resident #2 was taken to the nurses' station area and sat down into a chair. After the resident had been sitting down in the chair to get him to calm down, he stood up and became argumentative. She then helped the other two CNAs sit the resident back down into the chair. During the interview the CNA reported she had received some training on dealing with residents with dementia and behaviors but felt they needed more resident specific behavior training so they knew what to do for each different resident they had. She stated staff had asked for additional training but the management staff just told them to offer someone food or snacks when they were having behaviors. During an interview on 04/28/26 at 12:59 P.M., CNA #220 stated she was working the night of 04/11/26, when the incident occurred involving Resident #2. She recalled running down the hall that evening to respond to the nurse yelling for help. She and CNA #210 took Resident #2 up front, as the resident had been hitting another resident. She stated they arm to armed him, explaining it as wrapping their arms around the resident's arms (on both sides of the resident). She stated they helped him into the chair across from the nurses' station. He sat there for a few minutes, but when staff were talking to one another, he jumped up and started to go at CNA #210. They grabbed a hold of the resident and arm to armed him back into the chair. The CNA revealed during the incident the resident screamed a little bit. During an interview on 04/28/26 at 2:07 P.M., CNA #210 stated she and CNA #220 were in the dining room when they heard screaming. They ran down the hall and saw Resident #2 had a hold of the nurse. The nurse was trying to get him out of the room and the resident was screaming and kicking her. They were trying to take him gently at first by asking him to come with them. He refused, so they asked the nurse what she wanted them to do. The nurse told them she did not know but just take him out of there. They arm to armed him taking their arm and putting them under his. During the interview, the CNA revealed staff from the second floor came up, but she did not feel they were needed. She was not sure who called for them but did not feel they helped matters. She felt the additional staff present just made things worse and got the resident more agitated and it was probably overwhelming for the resident to have them all around him. In addition, during the interview the CNA revealed she did not feel staff were properly trained to deal with residents with aggressive behaviors. They received annual training, but it was over the computer and there was nothing hands on. They were not taught how to deal with aggressive or violent behaviors. Review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Gallipolis	170 Pinecrest Drive Gallipolis, OH 45631

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility policy on Behavior Management Program revised 10/27/23 revealed residents exhibiting behaviors negatively affecting self or other residents or with new behaviors negatively affecting self or other residents would be reviewed by the Behavior Management team which may include but was not limited to the Activity Director, Social Services Director, nurse manager, physician, contracted behavioral health partner's prescriber (PA, psychiatrist, or NP), psychologist, and any other parties that the facility members deemed appropriate. The team would explore the root cause of behaviors/ mood. The team would identify target behaviors and an individualized plan of care. The team would use non-pharmacological interventions, when applicable, to minimize the need for medication, permit the use of the lowest possible dose, or allow medications to be discontinued.This deficiency represents non-compliance investigated under Incident Number 299063.