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	04/21/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on observation, record review, facility policy review and interview, the facility failed to implement adequate and effective interventions to promote healing and prevent the deterioration of a left below the knee surgical site with staples for Resident #48 at the time of the resident's admission. This affected one resident (#48) reviewed for surgical wounds and for pressure wounds. Actual harm occurred on 03/25/25 when Resident #48, who was assessed to have hemiplegia affecting his left side with the need for (staff) assistance to turn and reposition in bed, did not have interventions in place to alleviate pressure and promote optimal healing of the resident's left below the knee surgical site resulting in a decline and worsening of the wound. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including acquired absence of left leg below knee, need for assistance with personal care, weakness, cerebral infarction, atherosclerosis of native arteries of extremities with gangrene, left leg, hemiplegia, affecting left non-dominant side, dementia, and chronic obstructive pulmonary disease. Review of Resident #48's admission skin assessment dated [DATE] revealed the resident had a left below the knee amputation with 35 surgical staples measuring 7.82 centimeters (cm) by by 2.87 cm. Review of Resident #48's nursing admission evaluation dated 03/20/25 revealed the resident required at least one person assistance with bed mobility. Review of the plan of care dated 03/20/25 for Resident #48 revealed the resident had impaired skin integrity related to recent surgery; mobility status as evidenced by: surgical wound to left leg with no intervention to elevate the left stump. Further review of the resident's plan of care revealed an activity of daily living self-care performance deficit related to acquired left below the knee amputation and hemiplegia affecting left dominant side with an intervention of bed mobility requiring a one person assist. Review of Resident #48's Braden Scale for Predicting Pressure Sore Risk dated 03/20/25 revealed a score of 17.0 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at risk for skin breakdown. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the active physician orders for Resident #48 dated 03/20/25 revealed to encourage to turn and reposition frequently when in bed to prevent skin breakdown. Further review of the active physician orders for Resident #48 revealed no order to elevate the left below the knee amputation stump. Review of the medical record for Resident #48 from 03/20/25 through 03/24/25 revealed no documented evidence of elevation of the left stump, the resident being turned every two hours, the resident refusing to be turned or that the resident favored his left side. Review of an Interdisciplinary team (IDT) functional assessment for Resident #48 dated 03/24/25 revealed the resident still required substantial/maximal (staff) assistance with bed mobility. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 which suggested moderate cognitive impairment. The resident was assessed to require substantial/maximal assistance with shower/bathe self, bed mobility and total dependence on staff for toilet hygiene and transfers. This resident was also assessed to be at risk for developing pressure ulcers, had an unstageable deep tissue injury not on admission and a surgical wound. Review of Resident #48's left below the knee amputation surgical wound assessment dated [DATE] revealed the site measured at 6.64 cm by 10.20 cm and was noted to have declined. Review of the active physician's order for Resident #48 dated 03/25/25 revealed to encourage the resident to float left stump. Observation on 04/14/25 at 10:38 A.M. of Resident #48 revealed the resident was on his left side in bed with his left stump not floated/elevated. Observation on 04/14/25 at 12:41 P.M. of Resident #48 revealed the resident was on his left side in bed with his left stump not floated/elevated. Interview on 04/14/25 at 12:51 P.M. with Licensed Practical Nurse (LPN) #104 revealed Resident #48 never refused care and required (staff) assistance to be turned in bed. Observation on 04/15/25 at 10:26 A.M. revealed Resident #48 was in bed on his left side. Observation on 04/15/25 at 1:23 P.M. revealed Resident #48 was in bed on his left side. Observation on 04/15/25 at 1:28 P.M. with Certified Nurse Assistant (CNA) #205 verified Resident #48 was positioned on his left side. Interview on 04/16/25 at 9:25 A.M. with Registered Nurse (RN) #196 revealed Resident #48 never refused care and required (staff) assistance to be turned in bed. Interview on 04/16/25 at 9:27 A.M. with CNA #173 revealed Resident #48 never refused care and did favor his left side. The CNA did not recall propping (floating/elevating) the resident's left stump since he had been admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/16/25 at 9:29 A.M. with Resident #48 revealed he needed help when moving in bed because his left side was so weak. The resident stated he sometimes had a pillow under his legs but not always. The resident also revealed he did not refuse to allow staff to turn him in bed when staff ask and help him turn. At this time, the resident was observed on his left side with his left stump not floated/elevated. Observation on 04/16/25 at 9:31 A.M. with RN #196 verified Resident #48 did not have his left stump floated/elevated and the resident was on his left side with no interventions in place to assist with off-loading the pressure to his left side and/or to promote the healing of the surgical wound. Interview on 04/16/25 at 1:29 P.M. with the Director of Nursing (DON) revealed if a resident, who required (staff) assistance, refused to be turned and repositioned or was refusing to off-load/float an extremity, it was to be documented, and the physician was to be notified. Observation on 04/16/25 at 2:01 P.M. revealed Resident #48 was on his left side. Interview on 04/16/25 at 2:19 P.M. with the DON revealed Resident #48 had refused a few times to turn and reposition since being admitted to the facility. During the interview, the DON revealed the resident favored his left side and no interventions had been implemented to help off-load pressure such as pillows or a wedge. The DON also verified no orders or documentation to float/elevate the left stump were in place at the time of admission. Orders were not implemented until 03/25/25 when the resident's left below the knee amputation surgical site worsened. The DON verified orders/interventions should have been in place for the left stump to be floated at the time of admission. Interview on 04/16/25 at 2:29 P.M. with Certified Nurse Practitioner #170 revealed he was never informed of Resident #48 refusing to turn and reposition in bed or that the resident preferred his left side. Observation on 04/17/25 at 9:11 A.M. of Resident #48 revealed the resident was on his left side with no interventions to help off-load pressure/promote healing and the resident's left stump not being floated. At the time of the observation, interview with the resident revealed he does prefer to be positioned on his left side better but did not recall the staff placing pillows or a wedge so that he could lay on his left side with less pressure. Observation on 04/17/25 at 11:25 A.M. with CNA #168 verified Resident #48 was positioned on his left side with no interventions in place to off-load pressure and the resident's left stump not floated/elevated. Review of the facility policy titled Pressure Ulcer/Skin Breakdown-Clinical Protocol revised 03/20/2024 revealed the plan of care for prevention and/or treatment would include a turning schedule/off-loading.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on record review, observation, interview, and policy review the facility failed to implement interventions to promote skin integrity for a resident ordered to wear a knee brace. This affected one resident (#48) of one resident reviewed for skin integrity. Findings Include: Review of the medical record for Resident #48, revealed an admitted [DATE] (from the hospital). Diagnoses included but were not limited to acquired absence of left leg below knee, need for assistance with personal care, weakness, cerebral infarction, atherosclerosis of native arteries of extremities with gangrene, left leg, hemiplegia, affecting left nondominant side, dementia, and chronic obstructive pulmonary disease. Review of the hospital discharge paperwork dated 03/20/25 for Resident #48 revealed a left knee immobilizer to be on at all times. Review of the plan of care dated 03/20/25 for Resident #48 revealed the resident had impaired skin integrity related to recent surgery; mobility status as evidenced by: assist resident with turning and repositioning as needed. Further review of this resident's plan of care revealed activity of daily living self-care performance deficit related to acquired left below the knee amputation and hemiplegia affecting left dominant side with the intervention of bed mobility requiring a one person assist. Review of Resident #48's nursing admission evaluation dated 03/20/25 revealed the resident to need at least one person assistance with bed mobility. Review of Resident #48's Braden Scale for Predicting Pressure Sore Risk dated 03/20/25 revealed a score of 17.0 on a scale of 6 (high risk) to 23 (no risk) which indicated the resident was at risk for skin breakdown. Review of the physician's order dated 03/20/25 at 9:37 P.M. revealed a brace to the left below the knee amputation to be on at all times every day and night shift. Further review of this resident's physicians order dated 03/20/25 revealed to encourage to turn and reposition frequently when in bed to prevent skin breakdown. Review of Resident #48's daily skilled assessments dated 03/20/25 through 03/24/25 revealed skin assessments were completed. Review of the medical record for Resident #48 from 03/20/25 through 03/24/25 revealed no documentation of refusing to be turned every two hours and that this resident favored his left side. Review of the physical therapy notes dated 03/24/25 for Resident #48 revealed alerted nurse of skin breakdown observed from knee immobilizer, nursing assessed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's medical record revealed an assessment and treatment order for skin break down noted by physical therapy on 03/24/25. Review of Resident #48's wound assessment dated [DATE] revealed an in-house facility acquired deep tissue injury (DTI) (persistent non-blanchable deep red, maroon or purple discoloration intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) to the front left thigh that measured 1.60 CM (centimeters) by 7.21 CM. Review of the active physician's orders dated 03/25/25 for Resident #48 revealed to skin prep area to front of left thigh every day and night. Review of the medical record for Resident #48 from 03/25/25 through 04/01/25 revealed minimal documentation of the resident refusing to be turned every two hours and no documentation that this resident favored his left side. Review of Resident #48's wound assessment dated [DATE] revealed an in-house facility acquired unstageable slough/eschar area to the left popliteal fossa that measured 2.68 CM by 1.91 CM by 0.1. Observation on 04/14/25 at 10:38 A.M. of Resident #48 revealed the resident to be on his left side in bed. Observation on 04/14/25 at 12:41 P.M. of Resident #48 revealed the resident to be on his left side in bed. Interview on 04/14/25 at 12:51 P.M. with Licensed Practical Nurse (LPN) #104 revealed Resident #48 never refuses care and does need assistance to be turned in bed. Observation on 04/15/25 at 10:26 A.M. revealed Resident #48 in bed on his left side. Observation on 04/15/25 at 1:23 P.M. revealed Resident #48 in bed on his left side. Observation on 04/15/25 at 1:28 P.M. with Certified Nurse Assistant (CNA) #205 verified Resident #48 to be on his left side. Interview on 04/16/25 at 9:25 A.M. with Registered Nurse (RN) #196 revealed Resident #48 never refuses care, needs assistance to be turned in bed. Interview on 04/16/25 at 9:27 A.M. with CNA #173 revealed Resident #48 never refuses care and does favor his left side. Interview on 04/16/25 at 1:29 P.M. with the Director of Nursing (DON) revealed if a resident refuses to be turned and repositioned that need assistance and if a resident is refusing to float an extremity, it is to be documented, and the physician is to be notified. Observation on 04/16/25 at 9:31 A.M. with RN #196 verified Resident #48 to be on his left side. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/25 at 9:31 A.M. with Physical Therapist #171 revealed Resident #48 was in therapy on Monday which was 03/24/25 and she removed his brace and noticed the skin area to his left thigh and alerted the nursing staff to assess it. Interview on 04/17/25 at 9:33 A.M. with Licensed Practical Nurse (LPN) #104 verified Resident #48's DTI to the front left thigh was discovered on 03/24/25. Physical therapy alerted her, and she informed her Unit Manager who instructed her it would be measured the next day since Tuesdays are wound measurement day. LPN #104 verified no treatment and assessment was completed and implemented when the wound was discovered on 03/24/25. Review of the facility policy titled Pressure Ulcer/Skin Breakdown-Clinical Protocol revised 03/20/24 revealed residents with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing and prevent new ulcers from developing. The plan of care for prevention and /or treatment is to include a turning schedule/offloading care.

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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** 32654 Based on observation, record review, interview and facility policy and procedure review, the facility failed to ensure physician ordered fall interventions were in implemented as ordered for two residents (#6 and #40) with known falls. This affected two residents of six residents reviewed for accidents. The facility census was 81. Findings Include: 1. Review of the medical record for Resident #6 revealed an initial admitted [DATE] with the diagnoses including but not limited to Alzheimer's disease, atherosclerotic heart disease of native coronary artery, hypothyroidism, anxiety disorder, diverticulosis, dementia with other behavioral disturbances, psychosis, mood disorder, hyperlipidemia, insomnia, polyneuropathy, osteoarthritis, gastro-esophageal reflux disease, cardiomyopathy and dysphagia. Review of the plan of care dated 07/28/23 and last revised on 04/16/25 revealed the resident was at risk for falls/injury related to bladder incontinence, generalized weakness, history of falls, impaired cognition with decreased safety awareness, inability to use call light due to confusion, psychoactive medications use, lack of coordination, unsteadiness on feet and resident removes dycem from recliner. Interventions included encourage resident to rest whenever having periods of prolonged ambulation, non-skid strips to left side of bed, non-skid strops in front of recliner, staff education when aware of fire drill make sure she is aware of drill, therapy screen/evaluation/treat as needed, encourage resident to keep needed items within reach, encourage resident to wear glasses; assist with applying as needed, ensure the resident's room is free from accident hazards, non-skid footwear to reduce the risk of slipping as the resident allows, observe for changes in mobility, and place call light within reach. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident had one fall with injury since the prior assessment was completed. Review of the fall risk evaluation dated 04/06/25 revealed a score of six indicating the resident was at risk for falls. Review of the resident's monthly physician orders for April 2024 identified orders dated 01/12/23 right side of bed against wall per family request, 01/14/25 non-skid strips to left side of bed every shift for fall intervention, encourage grippy socks or proper footwear when out of bed and non-skid strips in front of recliner, check placement every shift. On 04/14/25 at 3:01 P.M., observation of Resident #6' room revealed no dycem to the seat of the resident's recliner, and no nonskid strips to the left side of the bed. On 04/15/25 at 3:20 P.M., interview with Licensed Practical Nurse (LPN) #189 verified the resident's physician ordered fall interventions were not implemented as ordered. (continued on next page)

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	365348	A. Building B. Wing	04/21/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #40 revealed an initial admitted [DATE] with the latest readmission of 02/10/23 with the diagnoses including but not limited to dementia with behavioral disturbances, chronic obstructive pulmonary disease, seizures, atrial fibrillation, schizophrenia, cardiomyopathy, secondary Parkinsonism, hypertension, dysphagia, aphasia, ataxia, anxiety disorder, gastro-esophageal reflux disease, anemia, major depressive disorder and hyperlipidemia. Review of the plan of care dated 08/10/23 and last revised on 01/24/24 revealed the resident was at risk for falls/injury related to bowel and bladder incontinence, generalized weakness, history of falls, impaired cognition with decreased safety awareness, opioid medication use, seizures, lack of coordination, difficulty walking, at risk for injury from hot liquids and will turn off pressure alarm. Interventions included dycem to wheelchair, fall mat to right side of bed, non-skid strips in front of toilet, do not leave unattended in the dining room, sensor pad alarm to bed, sensor pad alarm to wheelchair, sign in room for reminder to use call light, staff education assist resident up for meals, ensure alarms are in place and functioning, toilet frequently, toilet before and after meals, encourage resident to keep needed items within reach, encourage resident to keep wheelchair within reach, encourage resident to use call light, monitor resident's position to reduce the risk of slipping as the resident allows, observe for changes in mobility, place call light within reach, therapy screen/evaluation/treat as needed, skin breakdown, symptoms of delirium, falls, accidents, injuries, agitation, or weakness, observe for, record, and report to the nurse and/or physician any changes regarding the effectiveness of the bed modification or adverse or negative effects as a result of the bed modification, periodically evaluate the need for the resident's bed modification(s) and record continued risks and benefits of continued use of the bed modification(s), alternatives, and need for ongoing use and cool hot liquids prior to serving. Review of the resident's monthly physician orders for April 2025 identified orders dated 01/14/25 resident to have dycem present to wheelchair seat, non-skid strips in front of toilet, check placement every shift and sign in room for reminder to use call light and ask for assistance. On 04/15/25 at 3:15 P.M., observation of the resident with Certified Nursing Assistant (CNA) #126 revealed the resident had no dycem to the seat of his wheelchair. On 04/15/25 at 3:20 P.M., observation of the resident's room with LPN #189 revealed the resident had no nonskid strips in front of his toilet and the sign to remind the resident to use the call light and ask for assistance was behind the privacy curtain out of his sight. LPN #189 verified the fall interventions were not implemented as physician ordered, including the physician ordered dycem to his wheelchair seat. Review of the facility policy titled, Fall Prevention Program, dated 10/30/02 revealed each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls.

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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** 47987 Based on observation, interview, record review, and facility policy review, the facility failed to obtain a physician's order for the administration of oxygen therapy and post an oxygen warning sign. This affected one resident (#48) of one resident reviewed for respiratory care. The facility census was 81. Findings include: Review of the medical record for Resident #48, revealed an admitted [DATE]. Diagnoses included but were not limited to acquired absence of left leg below knee, need for assistance with personal care, weakness, cerebral infarction, atherosclerosis of native arteries of extremities with gangrene, left leg, hemiplegia, affecting left nondominant side and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 which suggests moderate cognitive impairment. The resident was assessed to require substantial/maximal assistance with shower/bathe self, bed mobility and total dependence on toilet hygiene and transfers. This resident was also assessed to be at risk for developing pressure ulcers and to have an unstageable deep tissue injury not on admission and a surgical wound. Review of the plan of care dated 03/23/25 for Resident #48 revealed this resident had an impaired pulmonary/respiratory status related to chronic obstructive pulmonary disease with an intervention to provide oxygen as needed when the resident exhibits signs/symptoms of difficulty breathing. Review of the active physician orders for Resident #48 revealed no order for oxygen therapy. Observation on 04/14/25 at 10:38 A.M. of Resident #48 revealed his door did not display an oxygen in use sign. Further observation revealed the resident in bed with his nasal cannula on the bed with an oxygen concentrator set to 2 liters. Observation on 04/15/25 at 10:26 A.M. of Resident #48 revealed his door did not display an oxygen in use sign and the resident to bed in bed with his nasal cannula on with the oxygen concentrator to be set to 2 liters. Observation and Interview on 04/15/25 at 9:31 A.M. with Registered Nurse #196 of Resident #48 verified no oxygen in use sign on his door and the resident to have a nasal cannula attached to an oxygen concentrator. Also verified no oxygen therapy physician order for the resident. Review of the facility policy titled Oxygen Administration revised 10/26/2023 revealed oxygen warning signs must be placed on the door of the resident's room where oxygen is in use and oxygen is administered under orders of a physician.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interviews and facility policy and procedure review, the facility failed to comprehensively assess and develop a comprehensive plan of care for one resident (#31) with post traumatic stress disorder (PTSD). This affected one of four residents reviewed for mood/behavior. The facility census was 81. Findings Include: Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the diagnoses including but not limited to psychosis, schizoaffective disorder, depressive type, hypertension, hypothyroidism, drug induced subacute dyskinesia, obstructive sleep apnea, tremor, anxiety disorder, severe morbid obesity, constipation, dissociative and conversion disorder, post-traumatic stress disorder, chronic kidney disease, insomnia, borderline personality disorder, major depressive disorder, bipolar disorder, osteoarthritis and overactive bladder. Review of the resident's initial social service history dated 01/19/23 revealed the resident did not have PTSD. Review of the resident's social service progress review dated 01/06/25 revealed the resident did not have PTSD. Review of the psychiatric progress note dated 03/20/25 revealed the resident's PTSD was chronic and controlled. The resident is currently on a regimen of Depakote, Latuda, Topiramate, Ingrezza, Buspar, and Wellbutrin. No new symptoms or concerns were reported during this visit. The plan was to continue with the current medication regimen. Encouraged resident to report any increase in PTSD symptoms or any side effects from the medication. Regular follow-ups will be scheduled to monitor the patient's response to the medication. Review of the resident's social service progress review dated 04/01/25 revealed the resident did not have PTSD. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had displayed hallucinations, delusions and behaviors not directed towards others. The assessment indicated PTSD was a current diagnoses. Review of the resident's plan of care revealed no care plan addressing the resident's triggers PTSD. On 04/17/25 at 9:48 A.M., interview with Regional Registered Nurse #207 verified the resident was not assessed for PTSD and a comprehensive plan of care was not developed to assist with the care of the resident's PTSD. (continued on next page)

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	365348	A. Building B. Wing	04/21/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Trauma Informed Care, dated 10/18/20 and last revised 10/24/22 revealed the policy of the facility to ensure residents who are trauma survivors receive culturally competent trauma informed care in accordance with professional standards of practice. Each resident will be screened for a history of trauma on admission. The facility social worker or designee will conduct the screening in a private setting. If the screening indicated the resident had a history of trauma and/or trauma related symptoms a physician's order will be obtained for the resident to be evaluated by a mental health professional. The facility will account for the resident's experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. A care plan will be initiated/updated to address those residents identified. Individualized approaches will be identified and interventions put into place.

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	04/21/2025

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32654 Based on observation and interviews, the facility failed to ensure opened multi-dose Tuberculin Purified Protein (TB) vials were dated when opened. This had the potential to affect all 81 residents residing in the facility. Findings Include: On 04/17/25 10:15 A.M., observation of the third floor medication room refrigerator revealed an opened vial of Tuberculin Purified Protein one milliliter (ml) was undated to when the first dose was obtained. Registered Nurse (RN) #196 verified the vial of TB solution was not dated when opened at the time of the observation. On 04/17/25 at 10:22 A.M., observation of the second floor medication room refrigerator revealed an opened vial of Tuberculin Purified Protein one milliliter (ml) was undated to when the first dose was obtained. Licensed Practical Nurse (LPN) #157 verified the TB solution was not dated when opened at the time of the observation.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on review of facility alternative dispute resolution agreements, resident interview, staff interview, record review, and policy review, the facility failed to ensure residents understood the agreement they signed. This affected two of three residents reviewed for arbitration agreements (Residents #15 and #68). The facility census was 81. Findings include: 1. Review of the record for Resident #68 revealed an admitted [DATE]. Review of a Minimum Data Set (MDS) assessment completed 01/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of a facility Alternative Dispute Resolution Agreement dated 01/23/25 revealed Resident #68 signed the agreement on 02/14/25. The agreement stated it demonstrated a mutual intention to resolve disputes between them outside of court and to submit their disputes to Alternative Dispute Resolution through mediation and/or arbitration. The form also stated that the resident had been offered to, or had been able to view an audio/visual recorded video that details this agreement and what it includes. Interview with Resident #68 on 04/16/25 at 4:05 P.M. revealed it was her signature on the agreement. However, she stated she did not watch a video and did not understand what she was signing. 2. Review of the record for Resident #15 revealed an admitted [DATE]. Review of a MDS assessment completed 12/13/24 and 04/15/25 revealed a BIMS score of 14, indicating intact cognition. Review of a facility Alternative Dispute Resolution Agreement dated 12/07/24 revealed Resident #15 signed the agreement on 12/16/24. The agreement stated it demonstrated a mutual intention to resolve disputes between them outside of court and to submit their disputes to Alternative Dispute Resolution through mediation and/or arbitration. The form also stated that the resident had been offered to, or have been able to view an audio/visual recorded video that details this agreement and what it includes. Interview with Resident #15 on 04/16/25 at 3:15 P.M. revealed she did not remember signing the dispute resolution agreement. She stated that is was not her signature on the form. She stated anytime she signed a document, she used her middle initial between her first name and last name. The signature on the agreement did not include a middle initial. She stated she probably would not have signed the agreement anyway if she understood what it was. Review of other documents signed by Resident #15 dated 12/05/24 including consents for flu vaccine, RSV vaccine, and bed rails revealed the resident used her middle initial when signing the forms. Interview with Regional Registered Nurse #207 on 04/16/25 at 3:20 P.M. confirmed other forms signed by Resident #15 contained her middle initial and the Dispute Resolution Agreement did not. She further stated the Admissions Director who also signed the agreement no longer worked at the facility. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Admissions Director #192 on 04/17/25 at 7:26 A.M. revealed the facility has a video for residents to watch that explains the arbitration agreement. Review of the facility policy titled Binding Arbitration Agreements dated 07/28/20 and revised 11/01/22 revealed this facility asks all residents to enter into an agreement for binding arbitration. The facility shall explain to the resident or his or her representative in a form and manner that he or she understands.