STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365426	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors West	375 West Main Street West Jefferson, OH 43162

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 - Minimal harm or potential for 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** 50008 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of facility surveillance footage, review of facility self-reported investigation, staff interviews, and review of facility policy, the facility failed to protect three residents (Resident #46, #74, and #75) from misappropriation when Former Licensed Practical Nurse (LPN) #200 misappropriated their pain medications. This had the potential to affect fifteen residents on the east unit under the care of Former LPN #200. The facility census at the time of the incident was 77 residents. Findings include: Review of medical record for Resident #46 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, peripheral vascular disease, chronic pain, and osteoarthritis. The care plan dated 07/28/23 revealed Resident #46 was at risk for pain related to past medical history and diagnoses, with the goal to not experience a decline in overall function related to pain or have an interruption in normal activities due to pain. One of the care planned interventions included for nursing to administer medications per orders and observe for effectiveness. Review of the medication orders reveled Resident #46 was prescribed Gabapentin 800 mg, one (1) tablet three times daily. Review of the Medication Administrative Record (MAR) revealed Resident #46 received the pain medication as ordered. Review of the pain vital records revealed that nursing staff assessed pain levels on each shift and documented the results. The medical record for Resident #46 was silent for concerns related to excessive or uncontrolled pain. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease and chronic pain syndrome. The care plan dated 12/17/23 revealed Resident #74 was at risk of pain related to diagnoses. Goals included for Resident #74 not to experience a decline in overall function related to pain or have an interruption in normal activities related to pain through next review. One of the interventions for Resident #74 included nursing to administer medications per orders and observe for effectiveness. Review of the medication orders revealed Resident #74 was prescribed Gabapentin 600 mg one (1) tablet three times daily. Review of the MAR revealed the resident received the medication as ordered. Review of the pain vital records revealed Resident #74 vacillated between a 0 (no pain) and 6 (moderate pain) prior to taking his pain medications, on a 0 (no pain) to 10 (severe pain) scale. The medical record was silent for concerns related to excessive or uncontrolled pain. Review of medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included paraplegia from an injury to the thoracic vertebra. Medication orders included Gabapentin 300 mg three times daily. The care plan dated 05/16/24 revealed Resident #75 was at risk for pain related to muscle spasms and verbal complaints of pain, goals included for Resident #75 not to experience a decline in overall function related to pain and to not have an interruption in normal activities due to pain. One of the care planned interventions was for nursing to administer medications per orders and observe for effectiveness. Review of the pain vitals revealed that on 01/02/25, Resident #75 had some changes to the Gabapentin order with the timing of the medication to help control pain more effectively. Review of his MAR revealed that Resident #75 received the pain medication as ordered. Review of Facility Self- Reported Incident, Number 254643 revealed on 12/02/24, it was brought to the Director of Nursing's attention the medication counts for Residents #46, #74 and #75 were not accurate. The Director of Nursing started to investigate and found the facility had received three cards of Gabapentin 600 milligrams (mg), totaling 81 tablets, for Resident #75. One of the cards received was unaccounted for, and 3 additional doses were unaccounted for. The facility had received three cards of Gabapentin 600 mg for a total of 66 tablets for Resident #74. One of the cards, 30 tablets, was unaccounted for. For Resident #46, one card, 30 tablets of Gabapentin 800 mg was received by the facility and four tablets were missing. Review on 01/06/25 of two minutes of facility video surveillance taken on 11/30/24 starting at 3:13 P.M. revealed Former Licensed Practical Nurse #200 diverted an entire row of a resident's blister pill package by popping the pills into a generic medication container. Former LPN #200 was then observed on the video to walk down the hallway away from the medication cart with the excessive number of pills in the generic container along with a personal water bottle. Interview with the Administrator on 01/06/25 at 9:37 A.M. revealed as soon as she was notified of the misappropriation, the Administrator contacted Former LPN #200 on 12/02/24 to ask her if LPN #200 had any knowledge of the missing Gabapentin. Former LPN #200 admitted to the Administrator the Gabapentin did go missing under her watch. The Administrator stated that the police and the Board of Nursing were notified about the allegations. Review of Former LPN #200's employee file revealed the employee had been educated on the abuse and misappropriation policy and resident rights on 11/21/23. LPN #200 is no longer employed at the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Controlled Substance Administration and Accountability revised on 10/26/23 revealed that nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing immediately. As a result of the facility's plan of correction, all witnesses were interviewed, three witnesses made voluntary statements to the police department, which is an open investigation. All residents that were under the care of Former LPN #200 were interviewed for pain levels and medication accuracy. The facility was audited with the assistance of the pharmacy and the medication carts were fully audited. The facility made account adjustments and paid for the pain medications that were misappropriated for Residents #46, #74, and #75. On 12/02/24, a medication diversion education was provided by the Director of Nursing (DON) to the nurses, med technicians and certified nursing aides. On 12/02/24, an abuse neglect and misappropriation education was completed by the DON to the managers and nursing staff. On 12/05/24, the abuse, neglect and misappropriation education was completed by the DON to all staff members. On 12/05/24, Former LPN #200 was reported to the Ohio Nursing Board. The deficient practice was corrected on 12/05/24 when the facility implemented the following corrective actions: As a result of the facility's plan of correction, started on 12/02/24: The facility filed a self-reported incident was opened with the state agency at 2:47 P.M. All witnesses were interviewed, the police department was notified and three witnesses made voluntary statements to the police department. All residents that were under the care of Former LPN #200 were interviewed for pain levels and medication accuracy. A full audit of the facility medication carts was conducted. With pharmacy assistance all medications were reconciled and the facility made account adjustments and paid for the misappropriated pain medications for Residents #46, #74, and #75. Medication diversion education was provided by the Director of Nursing to nurses, medication technicians and certified nursing aides. Abuse neglect and misappropriation education was started by the DON to managers and nursing staff. On 12/05/24, the abuse, neglect and misappropriation education was completed by the DON to all staff members. On 12/05/24, Former LPN #200 was reported to the Ohio Nursing Board. Interview with Certified Med Technician #104 on 01/06/25 at 9:07 A.M. revealed knowledge of the misappropriation of resident medications occurring and now resolved. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #125 on 01/06/25 at 9:23 A.M. revealed knowledge of the misappropriation of resident medications and stated as part of the facility's plan of correction, LPN #125 had participated in auditing the facility medication carts and conducted medication reconciliation. Interviews on 01/06/25 from 2:58 P.M. to 3:04 P.M. with Certified Nursing Aide (CNA) # 101, #184, #167 and Activities Aide #156 verified staff was able to verbalize knowledge of the abuse neglect and misappropriation policies with appropriate responses. This violation represents non-compliance investigated under Master Complaint Number OH00160674 and Complaint Number OH00160576.