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	05/21/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and review of facility policy, the facility failed to notify representatives or emergency contacts of room changes for Residents #9, #59, and #79. This affected three residents (#9, #59, #79) of three residents reviewed for room changes. The facility census was 71.Findings include:1. Review of Resident #79's medical record revealed an admission date of 12/11/25 and a discharge date of 02/07/26. Her diagnoses included chronic hepatic failure, unspecified mood disorder, metabolic encephalopathy, generalized anxiety disorder, and delusional disorder.Review of Resident #79's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed she had moderately impaired cognition.Review of Resident #79's profile revealed she had a daughter listed as an emergency contact.Review of Resident #79's census revealed she had a room change on 01/06/26.Review of Resident #79's progress note dated 01/06/26 revealed the interdisciplinary team discussed a new room change with the resident, however, there was no evidence the family was notified.Interview on 05/19/26 at 2:00 P.M. with Social Service Worker #4 verified there was no evidence Resident #79's daughter was informed of the room change.2. Review of Resident #9's medical record revealed an admission date of 01/23/26 with diagnoses including metabolic encephalopathy, depression, and anxiety.Review of Resident #9's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.Review of Resident #9's profile revealed he had a spouse listed as his emergency contact.Review of Resident #9's census revealed he had a room change on 05/07/26.Review of Resident #9's medical record revealed no evidence the resident or representative was notified of his room change.Interview on 05/19/26 at 12:12 P.M. with Resident #9's wife revealed she did not recall being notified of a room change.Interview on 05/19/26 at 2:00 P.M. with Social Service Worker #4 verified there was no evidence Resident #9's wife was informed of the room change.3. Review of Resident #59's medical record revealed an admission date of 10/25/23 with diagnoses including dementia, unspecified mood disorder, and depression.Review of Resident #59's quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition.Review of Resident #59's profile revealed her son was listed as her emergency contact.Review of Resident #59's census revealed she had a room change on 03/27/26.Review of Resident #59's medical record revealed no evidence the resident or representative were notified of the room change.Interview on 05/19/26 at 11:46 A.M. with Resident #59's son revealed he was unaware of any room changes the resident had.Interview on 05/19/26 at 2:00 P.M. with Social Service Worker #4 verified there was no evidence Resident #59's son was informed of the room change.Review of the policy ?Change of Room or Roommate' dated 10/30/23 revealed prior to making a room change all persons involved in the change such as residents and their representatives, were to be given as much advance notification as possible. The notice was to occur in a language and manner the resident and their representative understood and was to include the reason for the move. This violation represents noncompliance investigated under 2715610.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure family was invited to care conferences for one, (Resident #59) of three residents reviewed for care conferences. The facility census was 71.Findings include:Review of Resident #59's medical record revealed an admission date of 10/25/23 with diagnoses including dementia, unspecified mood disorder, and depression.Review of Resident #59's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.Review of Resident #59's profile revealed her son was listed as her emergency contact.Review of Resident #59's care conference dated 01/12/26 revealed there was no evidence her son attended or was invited.Interview on 05/19/26 at 11:46 A.M. with Resident #59's son revealed it had been a long time since he had participated in a care conference despite his desire to do so.Interview on 05/19/26 at 2:00 P.M. with Social Service Worker #4 verified there was no evidence Resident #59's son was invited to her last care conference in January 2026. Social Service Worker #4 reported Resident #59's son usually liked attending care conferences.Review of the policy ?comprehensive care plans' dated 06/30/22 revealed every effort was to be made to schedule care plan meetings at the best time of the day for the family and resident.This violation represents noncompliance investigated under complaint 2715610.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, interview and facility policy review, the failed to ensure Resident #74's medication administration was accurately documented. This affected one of three residents reviewed for medication concerns. The facility census was 69.Findings include:Review of Resident #74's medical record revealed an admission date of 08/26/25. Medical diagnoses include chronic obstructive pulmonary disease, acute on chronic respiratory failure with hypoxia, hypertension, heart failure, unspecified atrial fibrillation, and acute kidney failure. Review of Resident #74's Brief Interview for Mental Status (BIMS) dated 08/27/25 revealed a score of 14, indicating the resident was cognitively intact.Review of Resident #74's Medication Administration Record (MAR) for 08/2025 revealed missing documentation for scheduled medications. Review of Resident #74's MAR revealed there was no documentation completed on 08/27/25 for Atorvastatin Calcium (used to lower cholesterol) oral tablet 80 mg to be given at 9:00 P.M., Citalopram Hydrobromide (antidepressant) tablet 40 mg to be given in the evening, Carvedilol (used to treat high blood pressure) oral tablet 6.25 mg to be given at 9:00 P.M., Famotidine (used to decrease stomach acid) oral tablet 20 mg to be given at 9:00 P.M., Furosemide (diuretic) oral tablet 40 mg to be given at 9:00 P.M., Gabapentin (anticonvulsant) oral capsule 300 mg to be given at 10:00 P.M., Nystatin powder (antifungal) 10000 unit/GM to be given at 10:00 P.M. Review of Resident #74's MAR on 08/28/25 revealed there was no documentation for Resident #74's Levothyroxine Sodium (thyroid hormone) oral tablet 100 mcg to be given at 5:00 A.M., Gabapentin oral capsule 300 mg to be given at 6:00 A.M. and 10:00 P.M., Nystatin powder 10000 unit/GM to be given at 6:00 A.M. and 10:00 P.M.Review of Resident #74's progress notes confirmed there was no documentation in Resident #74's progress notes regarding missing documentation of medications in MAR for 08/27/25 and 08/28/25.Interview on 05/21/26 at 2:56 P.M. with the Director of Nursing (DON) confirmed documentation was missing for many medications for Residents #74 during 08/27 and 08/28.Review of the facility's policy titled, Medication Administration dated 01/17/23 confirmed licensed nurses or other staff who are legally authorized to do so in the state, ordered by the physician and in accordance with professional standards of practice should sign MAR after administered. Further review confirms they should also correct any discrepancies and report to nurse manager.This violation represents noncompliance investigated under 2609958.