STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365450	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Pomeroy	36759 Rocksprings Road Pomeroy, OH 45769

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of Emergency Medical Service (EMS) reports, review of hospital records, review of National Weather Service website, review of a facility investigation, and resident and staff interviews, the facility failed to ensure adequate and proper interventions were provided to prevent resident heat stroke during an outside activity. The facility also failed to ensure outdoor activities were planned and provided to meet the safety and total care needs of residents. This resulted in Immediate Jeopardy and actual harm and/or adverse health outcomes on 06/21/25 when facility staff took 13 residents to the zoo with the outside temperature reaching 88 degrees with a heat index of 90. The residents were at the zoo from approximately 12:00 P.M. to 6:00 P.M. Residents complained of not feeling well and being hot at the zoo. After leaving the zoo, the residents loaded a bus that had not been pre-cooled and drove to a local fast-food restaurant where they were provided meals while remaining on the bus. The bus was noted to be warm inside at that point. After leaving the restaurant, Resident #41 became unresponsive requiring 911 be called. Emergency Medical Services (EMS) arrived and assessed residents. Resident #41 had a temperature of 105. 7 degrees Fahrenheit and was transferred to the hospital where he was place on a ventilator and treated for heat stroke. Resident #35 was also noted by EMS to be unresponsive with a temperature of 104 degrees Fahrenheit. Resident #35 was transported to the hospital where she was admitted for treatment of heat stroke. This affected 13 residents (#4, #23, #28, #29, #30, #33, #35, #41 #47, #52, #57, #60, and #68) of 13 residents who went on the outing to the zoo. The facility was 69. On 06/26/25 at 3:40 P.M. the Administrator, Regional Clinical Support Nurse (RCDSN) #6, Director of Nursing (DON) #153, and Regional Administrator were notified of Immediate Jeopardy began on 06/21/25 when the facility proceeded with a planned outdoor activity outing despite outside temperatures reaching 88 degrees Fahrenheit with a heat index of 90 resulting in residents complaints of being hot and suffering heat stroke. The Immediate Jeopardy was removed on 06/23/25 when the facility implemented the following corrective actions: • On 6/21/25 at approximately 8:05 P.M. Certified Nursing Assistant (CNA) #117 identified Resident #41 had a change in level of consciousness (during a facility planned outing). 911 was called by CNA #80 and arrived on scene. Residents, including Resident #41 were assessed. Resident #41 and Resident #35 were transported to the hospital for treatment of increased (body) temperature and lethargy. • (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/21/25 at around 9:00 P.M. Regional Director of Operations (RDO) #3 instructed the Administrator and DON that outdoor outings were suspended until heat advisories or increase in temperature had been removed for the health and safety of residents. However, no outdoor outings were scheduled at the time, so no outdoor activities were canceled. Education was provided to the Administrator and DON on 6/21/25. The facility implemented a plan for all outdoor activities to be reviewed individually to determine if weather was appropriate for outdoor activity based on resident ' s status with final approval by the Administrator. • On 06/21/25 at 9:46 P.M. Medical Director #1 was notified by RCDSN #6 with orders obtained for skin assessment and vital sign monitoring for residents who returned to the facility from the outing on this date. • On 6/21/25 around 11:50 P.M. upon return from the outing, Licensed Practical Nurse (LPN) Unit Manager #156 assessed Resident 4, #23, #28, #29, #30, #33, #47, #52, #57, #60, and #68 for signs and symptoms of heat stroke. • Between 06/21/25 at 11:00 P.M. and 06/22/25 at 1:00 A.M. LPN #156 notified the responsible parties of Resident 4, #23, #28, #29, #30, #33, #35, #41, #47, #52, #57, #60, and #68, who were on the outing of the situation and of any negative outcomes. • On 06/22/25 LPN #156 re-assessed Resident 4, #23, #28, #29, #30, #33, #47, #52, #57, #60, and #68. • On 06/23/25 Senior DON #163 and RDCNS #6 re-assessed Resident 4, #23, #28, #29, #30, #33, #47, #52, #57, #60, and #68. The assessment included vital signs, skin assessments and psychosocial assessments. • On 06/23/25 at around 2:00 P.M. an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Administrator, DON, and Medical Director #1 and discussed plan of correction and root cause analysis. During QAPI, the facility identified the root cause of the incident was that the facility took residents to the zoo when they were then exposed to high heat for an extended period of time. Interventions including increase fluid intake, sunblock, periods of time in air-conditioned facilities or shaded areas, and umbrellas and fans, were ineffective. • (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 06/23/25 RDCSN #6 provided education to all staff that if the temperature increased outside or there was a heat advisory then all outings would be placed on hold and re-scheduled for a later date with Administrator final approval. • On 06/23/25, all staff education was completed by RDCSN #6 related to signs and symptoms of heat stroke and prevention of heat stroke. Education was also provided related to heat advisories/increased temperature for prevention with the following; appropriate actions should be in place for residents that go outside to include the use of sunscreen with frequent reapplication, residents to be dressed in light clothing, limit time outdoors, and avoid being in direct sun light as much as possible, with increased fluids being offered and encouraged. As of 06/23/25 all staff had been education with the exception of two staff members, one of which was on medical leave and the other staff member on vacation. These staff would be educated prior to their next working shift. • The facility implemented a plan for RDCSN #6/designee to provide staff training to all new hires related to heat stroke, heat advisories/increased temperature. • Beginning 06/25/25 the facility implemented a plan for the DON/Designee to conduct audits five times per week (Monday-Friday) of three random residents who spend time sitting outside to ensure no sunburn occurred and no signs or symptoms of heat stroke occurred as well. During a heat advisory the DON/designee would then assess all residents who spend time outside. • Beginning on 06/25/25 (Monday-Friday) the facility Administrator/designee would review to see if any resident outings were scheduled and if appropriate based on weather conditions. • The facility would complete weekly Ad Hoc QAPI meetings for four weeks to review audits and ensure effectiveness of plan. Although the Immediate Jeopardy was removed on 06/23/25 the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1. Review of the medical record for Resident #41 revealed an admission date of 08/10/25 with diagnoses including cerebral infarction with hemiplegia, chronic obstructive pulmonary disorder, congenital hydrocephalus, hypertension and gastroesophageal reflux disease. Resident #41 ' s brother was listed as his power of attorney (POA). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plan dated 9/28/23, revealed Resident #41 was at risk for altered activity patterns/pursuits related to frequent naps/sleeping during the day. Interventions included 1:1 visit from staff and volunteers, allow the resident to make choices/decisions about their preferred activity pursuits, encourage activities that assure success and are non-threatening. The care plan revealed the resident enjoyed outside activities and pets/animals. Review of the care plan dated 01/31/24 revealed Resident #41 had an activities of daily living (ADL) self-care performance deficit related to generalized weakness, hemiplegia, poor coordination, age-related cognitive decline, developmental delay, chronic obstructive pulmonary disorder, difficulty walking, cerebral infarction and history of falls. Interventions included providing resident with set up for meals, set up/clean up assist with toileting hygiene and transfers. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had cognitive impairment. The assessment revealed Resident #41 used a wheelchair for mobility and required (staff) set up assistance with meals, toileting hygiene and transfers. Review of a nursing note authored by DON #153 dated 06/21/25 at 9:33 A.M. revealed Resident #41 left the facility with staff for an outing at Columbus Zoo. Review of a nursing note authored by Registered Nurse (RN) #73 dated 06/21/25 at 8:25 P.M. revealed this nurse received a phone call from the facility staff (on the outing) stating Resident #41 was being sent to the emergency room. The physician was notified, and a message was left on voice mail for the POA. RN #73 called report to the Emergency Room. Review of the Emergency Medical Services (EMS) run sheet dated 06/21/25 revealed Medic #204 responded to address for emergency status. Upon arrival the medic crew were greeted by nursing home staff that were driving the bus. The staff stated (Resident #41) had been unconscious for roughly 15 minutes and they had nowhere to stop so they drove to the nearest rest stop. The medic crew assessed Resident #41 who had no response to any stimuli and presented red, dry and hot. A 12 lead ECG was obtained with baseline vitals. The ECG showed normal sinus rhythm and vital signs within normal ranges. With the assistance from the local fire department the resident was extracted from the bus via mega mover and placed on the cot. The Medic crew established intravenous access in the left antecubital space. A rectal temperature was obtained at 105.7 degrees Fahrenheit. Ice packs were placed on the groin area of the resident due to the high rectal temperature and need for passive cooling. Resident #41 began to vomit, and medic crew suctioned as needed to keep the airway clear. Resident #41 was transported to the local hospital as emergent status and turned over to the nursing staff and physicians at the emergency room. Review of the hospital documentation revealed Resident #41 presented to the emergency department on 06/21/25 with altered mental status from heat exposure and initial temperature of 105.5 degrees Fahrenheit. The resident was cooled and the temperature dropped to 95.5 degrees Fahrenheit. The resident was currently on a Bair Hugger (a convective temperature management system used in a hospital to maintain a person ' s core body temperature) and intubated. Magnesium had been replaced, and phosphate had been ordered. The resident was awaiting transport to a Columbus hospital Intensive Care Unit (ICU). Attempted to contact family, however, no contacts were available in the chart and no decision maker present at the bedside. Resident #41 was admitted to Ohio Health Hospital in Columbus on 06/22/25 from an outlying hospital with diagnosis of severe sepsis, bronchitis and heat stroke. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record revealed Resident #41 was re-admitted to the facility on [DATE] at 4:16 P.M. Observation on 06/30/25 at 11:01 A.M. of Resident #41 revealed the resident was up in his wheelchair, dressed appropriately, clean, dry with no wetness or odors noted. He was pleasant but difficult to understand. 2. Review of the medical record for Resident #35 revealed an admission date of 02/09/24 with diagnoses including cerebral infarction, hemiplegia, hypertension and legal blindness. Review of the care plan dated 01/12/24 revealed Resident #35 was at risk for altered activity patterns/pursuits related to impaired mobility and lack of interest in activities. Interventions included 1:1 visit from staff and volunteers as resident would allow, encourage activities that assure success and were non-threatening. The care plan revealed the resident enjoyed group activities, outside activities, religious activities and pets/animals. Review of the care plan dated 02/22/25 revealed Resident #35 had an ADL self-care performance deficit related to weakness, cerebral infarction and hemiplegia. Interventions included supervision with eating, one to two persons for assistance with toileting, and bed mobility, and one person assistance with transfers, and hygiene. Review of the most recent MDS assessment dated [DATE] revealed Resident #35 had intact cognition. The assessment revealed Resident #35 was independent with eating, dependent upon staff for toileting and hygiene and needed substantial to maximum assistance with transfers. Resident #35 received hospice care and services. Review of a nursing note authored by DON #153 dated 06/21/25 at 8:27 A.M. revealed Resident #35 left the facility with staff to go to the Columbus Zoo. Resident #35 received all morning medications and early evening medications were given to the staff to be administered during the outing. Review of a nursing note authored by RN #73 on 06/21/25 at 8:36 P.M. revealed Resident #35 was being sent to the local emergency room. The physician was notified, and a message was left for the resident ' s POA. RN #73 called report to the local emergency room. Further review revealed at 9:37 P.M. the POA called back and was made aware of the situation with Resident #35. Review of a nursing note authored by RN #73 dated 06/22/25 at 12:00 A.M. revealed the nurse called the local hospital to get a report on Resident #35. Resident #35 was up and talking. Resident #35 was going to be admitted to an outside hospital related to diagnosis of heat stroke. The physician was notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Emergency Medical Services (EMS) run sheet dated 06/21/25 revealed Medic #201 was dispatched to the rest stop on Route 33 in Rockbridge for a mass casualty. On arrival at the scene, the Incident Commander (IC) instructed this medic to join Medic #203 with their patient. The patient (Resident #35) was on hospice per the nursing home staff. The EMS report included Resident #35 was on a bus with nursing home staff after a trip to the zoo when the bus overheated and the driver pulled off into the rest area. Resident #35 had signs and symptoms of heat stroke, sun stroke, altered mental status and fever. The resident was responsive to verbal stimuli and went in and out of responsiveness. The resident had altered mental status due to heat emergency, was unable to walk and was unable to get off of the bus. Resident #35 had an oral temperature of 104 degrees Fahrenheit and there was a missed intravenous attempt in the left hand. Resident #35 had ice packs under her armpits and a patent airway, breathing unlabored, skin hot to the touch and pulses were rapid. Resident #35 opened eyes to verbal stimuli then goes unresponsive intermittently and intravenous access successful in resident ' s right antecubital and a 1000 milliliter bag of fluids started wide open and approximately 500 milliliters of fluids was given by arrival to emergency room. The decision not to intubate was related to the residents ' hospice status. A 12 lead ECG was completed showing sinus tachycardia. Review of the hospital documentation for Resident #35 revealed the resident presented to the emergency department with altered mental status. The resident was traveling from Columbus in a bus from a nursing home after visiting the zoo. Several residents were noted to become overheated and altered. Resident #35 ' s temperature was noted to be 104 degrees Fahrenheit by the EMS. The resident required immediate attention upon arrival. Cooling measures were initiated with ice packs to neck/axilla/groin areas with intravenous fluids infusing. Also cooling fans and misting were initiated. The resident had improvement in temperature as well as mental status. The troponin blood level was elevated to 497 with no complaints of chest pain, likely demand related. The hospital records included the resident ' s daughter would like a full work up including cariology evaluation and would pursue intervention if it was deemed appropriate despite her hospice status. Impression was a heat stroke, sepsis and non-ST elevated myocardial infarction. Review of the discharge hospital documentation dated 06/22/25 revealed a discharge diagnosis of heat stroke likely due to no air conditioning while being transported to the zoo. The resident returned to normal at the time of discharge. Elevated troponin levels likely secondary to dehydration with no cardiac etiology indicated. Resident #35 was admitted to the hospital from [DATE] through 06/23/25 with diagnoses of heat stroke and elevated troponin level likely secondary to dehydration. Review of a nursing note authored by RN #62 dated 06/23/25 at 10:00 P.M. revealed Resident #35 was re-admitted to the facility. Observation on 06/25/25 at 10:17 A.M. revealed Resident #35 was lying in bed with the television on. An interview with the resident at the time of the observation revealed Resident #35 stated she went to the zoo and got overheated. Resident #35 stated she went to the hospital but stated she did not remember much about the day. The resident did not recall eating a sack lunch at the zoo or eating at a fast-food restaurant on the way home. The resident was unable to recall when she got too hot. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the EMS run sheets revealed Resident #30, #23, #57, #29, and #28 refused to be assessed or provided care and treatment when EMS were on scene on 06/21/25. Residents #33, #47, #60 #52, #4 and #68 were assessed with recommendations for emergency room visit for care and treatment but refused. Interview on 06/25/25 at 8:00 A.M. with the Administrator revealed the facility had a zoo trip/outing on 06/21/25 of 13 residents, Resident #4, #23, #28, #29, #30, #33, #35, #41, #47, #52, #57, #60, and #68, six staff members (Administrator, DON, Activity Director #178, Activity Assistant #109, Housekeeping Supervisor #101 whom was also Certified Nursing Assistant (CNA), and two additional CNAs #80 and #117) and four volunteers. All 13 residents and two CNAs rode the facility bus; the rest of the staff/volunteers followed in their own cars. During the outing, two of the residents, Residents #35 and #41 were transported to the hospital. The Administrator stated on the way home from the Columbus Zoo, the bus overheated-meaning the temperature inside the bus was hot. The residents and staff had eaten fast food while on the bus, about 10 minutes from the zoo. Resident #41 started complaining of his stomach hurting and the two CNAs on the bus thought he was upset after eating. Resident #41 started to get restless, jerking on other people ' s seats and opened the emergency window on the bus. The staff pulled the bus over to fix the window, and the Administrator kept going down the road to the roadside rest. When they started back on the road, Resident #41 started getting worse. Resident #41 was lethargic and not talking to staff. The staff pulled over again at the roadside rest in Rockbridge and the Administrator, who is also a registered nurse, got on the bus to assess the resident. Resident #41 was not good enough to drink and had a strong fast pulse at 120 beats per minute. The Administrator poured room temperature water on him. The Administrator stated the van was really hot inside (all the doors and windows were open at that time) and she did not know why it was so hot. One of the CNAs called 911 and she continued to try to cool the resident off. The local EMS and fire department arrived. The person seated behind Resident #41, Resident #35, was flushed. The medics checked everyone ' s temperature and asked if they wanted to go to the hospital. Residents #35 and #41 were taken to local hospital emergency rooms. All the residents were removed from the bus and five sat in her car with the air conditioning on. The Administrator stated again she did not know why the bus was so hot; stating it usually takes about 15 minutes to cool down. When she was getting off the bus, she felt heat coming from under the driver ' s seat. She then called the Maintenance Director #90, and he was able to reach the sister facility close by who came and transported the residents back to the facility on their bus. Once the residents arrived back at the facility they were assisted inside, provided care and got ready for bed. The Administrator revealed the temperature that day was 88 degrees Fahrenheit, and she stated they stayed indoors most of the time while at the zoo. The Administrator stated they entered the zoo about 12:00-12:30 P. M. and around 4:00 P.M. she prompted the residents to wrap it up. Some of the residents wanted to go home and some wanted to see one more animal. They left the zoo about 6:00 P.M. The Administrator stated residents did complain about being hot at the zoo. The staff would take them to cool areas and give them cool wet wash cloths. The residents did not want to drink water because they did not want to go to the bathroom. The Administrator stated they had umbrellas, sunscreen, portable fans, sunglasses, cold wet wash cloths and six cases of water in coolers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility provided investigation timeline authored by the Administrator, dated 06/26/25 at 1:00 P. M. revealed 13 residents and six staff arrived at the Columbus Zoo (on 06/21/25) at 11:40 A.M. and entered the zoo at 12:35 P.M. The residents were provided with a sack lunch to eat under the umbrellas at the tables in the front of the zoo. At 1:10 P.M. the residents went to an indoor exhibit, at 2:00 P.M. the residents went into the air-conditioned conservation education rooms, and at 2:15 P.M. back outside to see the polar bear exhibit. At 2:30 P.M. the residents went inside to the air-conditioned polar bear exhibit and at 3:45 P.M. went to the Kudu-Shaded area. At 4:30 P.M. the Administrator informed the group they were going to wrap things up. The residents requested to see at least one animal of their choice. One group went to the kangaroos and the other group went to the aquarium. At 5:30 P.M. the groups were told to go to the front and get ready to board the bus. The residents left the zoo at 6:12 P.M. and arrived at fast food restaurant at 6:30 P.M. All residents were provided with a meal and drink. The Administrator asked why the windows were open and the residents replied they wanted air blowing. At that time the residents verbalized all were okay, just tired. At 6:50 P.M., they left the fast-food restaurant. At 7:35 P.M. the van pulled over onto an exit in Canal [NAME] due to Resident #41 ' s complaints of stomach pain and was restless (which was common when he needed to use the restroom). Resident #41 pulled open the emergency window and the van stopped to close it. At 8:01 P.M. Resident #41 was lethargic and the CNA on the bus called the nurse (Administrator who was driving her personal car and was near the roadside rest and also a Registered Nurse). At 8:05 P.M. the bus pulled over to the roadside rest in Rockbridge. The nurse (Administrator) attempted to apply oxygen, and the resident refused. Resident #41 was lethargic and tried to drink water. Resident #41 was not flushed or clammy. Resident #41 then slumped over to his right side, called his name and did a sternal rub and the resident would groan. Resident #41 respirations were regular, and pulse was strong at 120 beats per minute. The nurse applied room temperature water over the resident multiple times and called 911. All residents were assessed by the Emergency Medical Services (EMS). Residents #35 and #41 were taken to local emergency rooms. The van was extremely hot with the windows and doors open during the EMS assessments and care. Residents were evacuated from the bus during and after assessments were completed. Five residents were placed in a vehicle with air conditioning and six were placed in the shade. At 9:00 P.M. a call was placed for alternate transportation from sister facility. At 11:50 P.M. the residents arrived back at the facility. Interview on 06/25/25 at 3:03 P.M. with Maintenance Director #90 revealed the facility van had monthly inspections and was inspected by the State Highway Patrol in May 2025 and passed. Maintenance Director #90 stated he was not aware of any issues with the air conditioning prior to the residents going to the zoo. He and the Administrator took the van out the day before the trip for an approximate 12-mile drive and he believed the air conditioning was working fine. He stated he had the air conditioner checked on 06/23/25 and it was slightly low on freon in the back of the bus unit. The Maintenance Director stated he installed two thermometers on the bus, one in the front and one in the back. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 06/25/25 at 3:20 P.M. with Housekeeping Supervisor #101 revealed she was involved in the zoo trip with the residents. She stated the trip was discussed a couple weeks prior as to whether the date should be changed due to how hot it was. This was discussed with CNA #117 and Activities Director #178 and Housekeeping Supervisor #101 revealed she thought the Activities Director had discussed this with the Administrator. Housekeeping Supervisor #101 stated she was told if the state called her for an interview (related to the incident) to only say nice things and not be negative. She also stated she wrote out a statement of what happened, but it was re-written by the DON due to the things she had written. Housekeeping Supervisor #101 revealed the group left the facility around 8:30-9:00 A.M. for the zoo with no stops on the way there. They arrived at the zoo around 12:30 P.M. and the residents ate their lunch outside at tables with umbrellas. Housekeeping Supervisor #101 stated she had Resident #41 in her group and each group went to different parts of the zoo. She stated they took rest breaks in the shade and drank water. The Housekeeping Supervisor revealed a lot of the residents had asked to leave at 2:00 P.M. but they did not leave, and were told they would leave at 4:00 P.M. At 5:00-5:30 P.M. the Administrator texted and said they were leaving. They loaded up the bus and left. The bus stopped at a fast-food restaurant. The residents stayed on the bus and the staff went in to get the food. The bus air conditioning was left running, but the doors were left open. When she stepped up on the bus to give the food to the residents the heat hit you in the face. Housekeeping Supervisor #101 did not ride the bus as she followed in a personal car. She stated after leaving the restaurant, the bus pulled off on an exit and the CNA driving called and stated that Resident #41 had opened an emergency window latch, but they were okay. About 20 minutes later the CNA called again to tell the Administrator that they needed her and that something was wrong with Resident #41. She called the CNA back and stated the Administrator was at the roadside rest and the CNA stated they did not need her to stop. They drove back to the facility and waited on the residents to return. The residents returned about 11:30 P.M. and staff helped them exit the bus. The residents were tired. Interview on 06/25/25 at 3:45 P.M. with Activity Assistant #109 revealed the Administrator planned the trip to the zoo after the residents mentioned they wanted to go in Resident Council. The Administrator scheduled the date to go. Activity Assistant #109 stated she did not hear anyone discussing the temperature prior to going on the trip. The residents left the faciity on the bus (on 06/21/25) around 8:30-9:00 A.M. and she drove her own car. The bus did not stop on the way there. Once at the zoo, they unloaded the residents, applied sunscreen, and stayed in the shade while the Administrator purchased the tickets. They went inside the park, toileted the residents and sat at tables with umbrellas and at lunch. Activity Assistant #109 stated she had different residents with her at different times. The plan was to leave around 2:00 P.M. but they arrived late so they stayed until 5:00-5:30 P.M. She stated if a resident stated they were hot they took them to the shade. Activity Assistant #109 did not stop at the fast-food restaurant with the bus nor was she at the roadside rest area. She went back to the facility and waited for the residents to return. She stated she was not aware of any problems with the air conditioning on the bus prior to the trip. The temperature that day was in the 80 ' s to 90 ' s. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365450	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Pomeroy	36759 Rocksprings Road Pomeroy, OH 45769

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 06/25/25 at 4:20 P.M with the DON #153 revealed the Administrator planned the zoo trip and the DON did not know if there was any discussion about going on a day with temperatures as high as they were. The DON stated on 06/21/25 it was in the mid 80 ' s with a decent breeze. DON #153 stated she did not discuss with the physician to see if it was okay for those residents to go on the trip. There were 13 residents and two CNAs on the bus, and she met them at the zoo around 11:30 A.M. (The DON stated she lived nearby) They started unloading residents while the Administrator went to purchase the tickets. They entered the zoo and ate lunch under the umbrella covered tables just inside the zoo. All the residents were given water. The DON stated she was with Residents #47, #52, #4, #35, #33 and #29 and Activity Director #178, the Administrator, CNA #80 and a volunteer. The DON revealed incontinence care was provided at least two times while at the zoo. There was not a specific or set time to leave, it was to be based on how well the residents did. Around 4:00 P.M. the residents started towards the front of the zoo to the shaded umbrella area. They then loaded the residents back on the bus. Resident #47 stated she did not feel good while in the zoo and they used wet wash cloths, encouraged her to drink fluids, put a fan on her and took her to an air-conditioned area. After about 10 minutes she felt better, and we went back out. When the bus left the zoo, the DON returned to her home. Interview on 06/26/25 at 5:18 A.M. with RN #103 revealed she was working as an aide on 06/21/25 night shift when the residents returned from the zoo around 11:00 P.M. RN #103 stated she helped unload residents off the bus and the Unit Manager/LPN #156 assessed the resident including vital signs. None of the residents complained about anything, however, their faces were red. When toileting and changing Resident #68, the resident smelled of urine, but her skin was intact. RN #103 stated she felt bad for the residents that went because they wanted to go but did not feel like it was a good idea for them to be out in the hot temperatures all day due to their medical conditions. Interview on 06/26/25 at 5:33 A.M. with CNA #170 revealed she was working on 06/21/25 when the residents returned from the zoo trip. The residents returned around 12:30 A.M. CNA #170 revealed upon their return, staff started providing care for the residents. Resident #68 had bowel movement on her and was changed. Resident #47 was also changed, and the resident ' s skin was red and the open area she had prior was worse and bleeding. Resident #47 reported the aides changed her at the zoo, but she was up all day in a wheelchair. Resident #47 was slumped over and sweaty and seemed to be lethargic from exhaustion. Resident #68 was very distressed