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	02/06/2025

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

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review transfer notices, staff interview, and policy review, the facility failed to ensure the local Ombudsman was notified of resident transfers as required. This affected two residents (#57 and #65) of two residents reviewed for hospitalization s. Findings include: 1. Review of Resident #57's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included acute on chronic respiratory failure with hypoxia, history of a tracheostomy (removed), seizures, adult onset diabetes mellitus, heart failure and cerebellar stroke disorder. Review of Resident #57's census tab and Minimum Data Set assessments under the electronic medical record (EMR) revealed the resident was hospitalized on [DATE] and did not return to the facility until 12/10/24. Review of Resident #57's progress notes revealed a nurse's note dated 11/30/24 at 8:57 P.M. that indicated the resident was transferred from the facility via local emergency medical services (EMS). The progress note did not specify the reason for the transfer or where the resident was being transferred to. A bed hold policy was indicated to have been provided to the resident at the time of his transfer. Subsequent progress notes indicated the resident was sent to the emergency room Review of an SBAR (Situation, Background, Assessment, and Request) communication form for Resident #57 dated 11/30/24 at 8:40 P.M. revealed the resident was noted to have seizure activity with a low oxygen saturation of 83% (92-100% normal) on 4 liters per minute (LPM) and possible aspiration. His pulse was 123 and his respirations were 18 with a blood pressure of 136/96. The resident was also found to be unresponsiveness and his respirations were indicated to be labored. He was found to be clammy, cool to touch, awake but not responding, and was noted to be wheezing when taking a breath. The physician was notified and a new order was received to send the resident out to the emergency room . The resident then began actively seizing and the staff assisted the resident to his side safely with the seizure lasting 1 minute and 45 seconds. The resident's breathing remained labored with his oxygen saturation starting at only 80% on room air. Oxygen was placed on the resident at 4 LPM raising his oxygen saturation to 83% by the time the squad arrived to transfer the resident to the emergency room . (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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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	The surveyor requested the facility provide all transfer notices that had been provided to the Resident #57 and/ or to his resident representative and the local Ombudsman. They provided a transfer notice and a bed hold notice that had been provided to the resident/ resident representative, but did not have evidence of the local Ombudsman being notified of the resident's transfer to the hospital as required. Findings were confirmed with Regional Director of Operations #200. On 02/05/25 at 2:30 P.M., Regional Director of Operations #200 reported the facility had reached out to the local Ombudsman's office and left a message on two separate voicemails to see if they had any documentation to support they had been notified of Resident #57's transfer to the hospital on 11/30/24. They were not able to get any confirmation from the Ombudsman's office to show the facility had notified them of the resident's transfer as required. Review of the facility's policy on Transfer and Discharge (revised 10/30/23) revealed it was the policy of the facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents were endangered. Transfer was defined as the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expected to return to the original facility. For an emergency transfer, the social service director or designee should provide notice of the transfer to a representative of the State Long-Term Care Ombudsman via a monthly list. 50538 2. Review of Resident #65's medical record revealed an admitted [DATE], a re-entry date of 11/08/24 and a discharge date of [DATE]. Further review revealed diagnoses including multiple sclerosis, right femur fracture, cellulitis of the right lower limb, osteoarthritis and anemia. Review of Resident #65's progress notes revealed he was sent to the local emergency roiagnom on [DATE] at 5:55 P.M. for an infection in his right lower extremity and that a copy of the bed hold policy was sent with him. In an interview on 02/06/25 at 2:15 P.M. Senior Director of Nursing #210 and Regional Director of Operations #200 confirmed the facility had no proof the ombudsman had been notified of Resident #65's transfer to the local emergency room .

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to develop and implement a baseline plan of care related to Resident #116's orthotic splint. This affected one resident (#116) of 19 sampled residents. Findings Include: Review of the medical record for Resident #116 revealed an initial admitted [DATE] with the diagnoses including but not limited to osteoarthritis right wrist, osteonecrosis of right carpus, severe protein calorie malnutrition, Kienbock's disease of adults, major depressive disorder, alcohol dependence with withdrawal delirium, altered mental status, confusional arousals, anxiety disorder, Wernicke's encephalopathy, repeated falls, anemia, abnormal weight loss, gastro-esophageal reflux disease, disorders of plasma protein metabolism, metabolic acidosis, seasonal allergic rhinitis, hypertension and allergy to mammalian meats. Review of the plan of care dated 01/20/25 revealed the resident is at risk for impaired skin integrity related to splint to right hand. Interventions included administer medications as ordered, apply protective barrier cream after incontinent episode, assist resident with turning and repositioning as needed, complete skin inspection weekly and as needed, consult Dietitian as needed, labs as ordered, notify nurse of any new areas of skin impairment noted during bathing or daily care, notify the physician of any new areas of skin impairment and therapy to screen/evaluate/treatment as needed. Review of the resident's nursing admission evaluation dated 01/20/25 revealed the resident had limited range of motion in the right hand. The resident's right orthotic brace was not addressed on the admission evaluation. Review of the February 2025 monthly physician orders identified orders dated 01/20/25 monitor scab to first digit to right hand daily until resolved, 01/21/25 maintain splint to right wrist, check placement and skin integrity every shift, non-weight bearing to right wrist, circulatory checks to right hand every shift, On 02/04/25 at 10:01 A.M., observation/interview with the resident revealed he had a black orthotic splint to his right hand/wrist. He reported he fell on the ice at home and the hospital said it wasn't broken but he felt it was. He said his fingers bent back and touched his forearm. His right hand was noted to be edematous around the the brace. The resident reported the brace felt tight. The resident denied having the brace adjusted. On 02/05/25 at 11:20 A.M., interview with Senior Director of Nursing (SDON) #210 confirmed a baseline plan of care was not developed containing the physician ordered instructions to care for the orthotic splint to the resident's right hand/wrist. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Baseline Care Plan, (last revised 12/28/23) revealed the facility will develop and implement a baseline plan of care for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

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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 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** 32654 Based on record review, interview and facility policy review, the facility failed to review and revise two residents (#5, #46) in the area of activities of daily living (ADL) and palliative care. This affected two residents (#5, #46) of 19 sampled residents. Findings Include: 1. Review of the medical record for Resident #5 revealed an initial admitted [DATE] with the latest readmission of 12/26/23 with the diagnoses including but not limited to cerebrovascular accident (CVA) with right sided hemiplegia, chronic obstructive pulmonary disease (COPD), aphasia, mild intellectual disabilities, dysphagia, idiopathic peripheral autonomic neuropathy, vertigo, protein calorie malnutrition, schizophrenia, bipolar disorder, osteoporosis, hyperlipidemia, peripheral vascular disease, cerebellar ataxia, hypertension, malignant neoplasm of prostate, solitary pulmonary nodule, dementia with agitation, major depressive disorder, benign prostatic hyperplasia, alcohol abuse and nicotine dependence. Review of the plan of care dated 10/30/23 revealed the resident had an activities of daily living (ADL) self-care performance deficit related to intellectual disability, lack of coordination, muscle weakness, hemiplegia, COPD and pain. Interventions included assist/grab bars to aide with bed mobility, the resident was independent with ambulation, bed mobility, dressing, transfers, toileting, required supervision with personal hygiene and dependent with eating, encourage participation in daily care and provide positive reinforcement for activities attempted and/or partially achieved, encourage resident to use call light when assistance is needed, honor resident's choices and preferences whenever possible, observe for pain during ADL tasks and report to nurse if observed, place assistive devices within reach, place call light within reach, therapy screen/evaluation/treatment as needed, report changes in ADL abilities to Nurse, Physician/NP/PA, and/or therapy, bent utensils at all meals and encourage resident to allow staff to shave them. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. Review of the monthly physician orders for February 2025 identified orders dated 11/26/24 regular diet, level one texture thin liquids, staff to feed, encourage to be upright with meals for fortified pudding with lunch/diner. Review of the resident's ADL documentation from 01/05/25 to 02/06/25 revealed the resident required extensive assistance with ADL. On 02/06/25 at 10:34 A.M., interview with Senior Director of Nursing (SDON) verified the lack of revision of the ADL plan of care to reflect the resident's current ADL status of extensive assistance with ADL. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #46 revealed an initial admitted [DATE] with the latest readmission of 04/02/24 with the diagnoses including but not limited to acute and chronic respiratory failure, severe morbid obesity, chronic obstructive pulmonary disease (COPD), hypothyroidism, depression, diabetes mellitus, pain in foot, sleep disorder, liver disease, fatty liver and gout. Review of the plan of care dated 10/17/23 revealed the resident had a terminal prognosis with admit to Compass Palliative Care with diagnoses of COPD. Interventions included administer medications as ordered and observe for effectiveness, allow resident to express fears and concerns related to terminal diagnosis, notify hospice/palliative team for additional emotional support services as needed, collaborate with the palliative/hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, involve resident, family, clergy and other team members as needed, evaluate for verbal and non-verbal signs and symptoms relating to pain, honor preference related to hospitalization s, notify hospice/palliative team for additional family support services if needed, notify hospice/palliative team if current pain medications is ineffective, provide care based on resident/family/responsible party's preferences related to end-of-life comfort measures, provide space and privacy for the family to spend time with the resident and provide time for the family/responsible party to express feelings about end-of-life prognosis for their loved one. Review of the resident's monthly physician orders for February 2025 identified orders dated 04/02/24 admit to Compass Palliative Care with diagnoses of COPD. On 02/05/25 at 4:25 P.M., interview with Registered Nurse (RN) #111 verified the resident's current hospice company was Buckeye Hospice. Review of the facility policy titled, Comprehensive Care Plan, (last revised 06/30/22) revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessments.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to provide ensure one resident (#24) who was dependent on staff assistance with nail care as physician ordered. This affected one resident (#24) of three residents reviewed for activities of daily living (ADL). Findings Include: Review of the medical record for Resident #24 revealed an initial admitted [DATE] with the latest readmission of 12/05/24 with the diagnoses including diabetes mellitus, polyneuropathy, spondylosis, disease of pancreas, gastro-esophageal reflux disease, osteoarthritis, disorders of urethra, obstructive and reflux uropathy, noncompliance with medical treatment and regimen, calculus of kidney, congestive heart failure, dysphagia, hypertension, anxiety disorder, atrial fibrillation, adjustment disorder with mixed disturbance of emotions and conduct, chronic pain syndrome, insomnia, major depressive disorder, basal cell carcinoma of skin of unspecified eyelid, acanthosis nigricans, hypothyroidism and hyperlipidemia. Review of the resident's plan of care dated 09/27/23 revealed the resident had self-care performance deficit related to muscle weakness, lack of coordination, need for assistance with personal care, stiffness of joints, atrial fibrillation and anxiety. Interventions included bilateral enables to bed, resident is to be upright for all meals, the resident requires two person assist with bathing, dressing, personal hygiene, toileting, transfers and supervision with eating, encourage participation in daily care and provide positive reinforcement for activities attempted and/or partially achieved, encourage resident to use call light when assistance is needed, honor resident's choices and preferences whenever possible, observe for pain during ADL tasks and report to nurse if observed, place assistive devices within reach, place call light within reach, provide cues and assist as needed to accomplish daily tasks, therapy to screen/evaluate/treat as needed, report changes in ADL abilities to Nurse, Physician/NP/PA, and/or Therapy and resident may utilize tilt and space wheelchair for locomotion. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident displayed verbal behaviors directed towards others. Review of the resident's February 2025 monthly physician orders identified orders dated 12/06/24 nurse to trim nails every Monday. Review of the resident's February 2025 Medication Administration Record (MAR) revealed the order was initialed on 02/03/25 indicating the resident's nails were trimmed. On 02/03/25 at 10:55 A.M., observation of the resident's fingernails revealed they were long, jagged with a brown substance under the nail. On 02/05/25 at 12:55 P.M., interview with the resident revealed her nails were not cut on 12/03/25 but are due for a cutting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 1:02 P.M., interview with Regional Director of Clinical (RDC) #220 confirmed the resident's nails were long, jagged and dirty. Review of the facility policy titled, Nail Care, (last revised 08/20/24) revealed the purpose of this procedure is to provide guidelines for the care of a resident's nails for good grooming and health. Routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis. Routine nail care includes trimming and filing, will be provided on a regular basis and as the need arises.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to ensure one resident (#46) received routine palliative care visits. Additionally, the facility failed to monitor one resident's (#116) orthotic splint causing increased edema. This affected two residents (#46, #116) of 19 sampled residents. Findings Include: 1. Review of the medical record for Resident #46 revealed an initial admitted [DATE] with the latest readmission of 04/02/24 with the diagnoses including but not limited to acute and chronic respiratory failure, severe morbid obesity, chronic obstructive pulmonary disease (COPD), hypothyroidism, depression, diabetes mellitus, pain in foot, sleep disorder, liver disease, fatty liver and gout. Review of the plan of care dated 10/17/23 revealed the resident had a terminal prognosis with admit to Compass Palliative Care with diagnoses of COPD. Interventions included administer medications as ordered and observe for effectiveness, Allow resident to express fears and concerns related to terminal diagnosis, notify Hospice/Palliative team for additional emotional support services as needed, collaborate with the Palliative/Hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, involve resident, family, clergy and other team members as needed, evaluate for verbal and non-verbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, increased anxiety, honor preference related to hospitalization s, notify Hospice/Palliative team for additional family support services if needed, notify Hospice/Palliative team if current pain medication(s) is ineffective, provide care based on resident/family/responsible party's preferences related to end-of-life comfort measures, provide space and privacy for the family to spend time with the resident and provide time for the family/responsible party to express feelings about end-of-life prognosis for their loved one. Review of the resident's monthly physician orders for February 2025 identified orders dated 04/02/24 admit to Compass Palliative Care with diagnoses of COPD. Review of the resident's hospice documentation revealed the resident had not had a visit from the contracted palliative care service since 12/14/24. On 02/06/25 at 8:42 A.M., interview with the Director of Nursing (DON) revealed the resident's palliative care company was scheduled but with the snow storm and sickness at the providers company she was not seen in the month of January 2025. Review of the facility policy titled, Hospice, (last revised 10/26/23) revealed when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental and psychosocial well-being. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #116 revealed an initial admitted [DATE] with the diagnoses including but not limited to osteoarthritis right wrist, osteonecrosis of right carpus, severe protein calorie malnutrition, Kienbock's disease of adults, major depressive disorder, alcohol dependence with withdrawal delirium, altered mental status, confusional arousals, anxiety disorder, Wernicke's encephalopathy, repeated falls, anemia, abnormal weight loss, gastro-esophageal reflux disease, disorders of plasma protein metabolism, metabolic acidosis, seasonal allergic rhinitis, hypertension and allergy to mammalian meats. Review of the plan of care dated 01/20/25 revealed the resident is at risk for impaired skin integrity related to splint to right hand. Interventions included administer medications as ordered, apply protective barrier cream after incontinent episode, assist resident with turning and repositioning as needed, complete skin inspection weekly and as needed, consult Dietitian as needed, labs as ordered, notify nurse of any new areas of skin impairment noted during bathing or daily care, notify the physician of any new areas of skin impairment and therapy to screen/evaluate/treatment as needed. Review of the resident's nursing admission evaluation dated 01/20/25 revealed the resident had limited range of motion in the right hand. The resident's right orthotic splint was not addressed on the admission evaluation. Review of the progress note dated 02/04/25 revealed the physician examined the resident due to edema and pain to the right hand/wrist. A new order was received for a two view x-ray of the right wrist and hand to rule out a fracture. The facility contracted x-ray company was notified of the need for the x-ray. Review of the progress note dated 02/05/25 at 7:11 P.M. revealed the radiology results were received revealing no gross osseous abnormality. Limited study for which fracture is not excluded. The Radiologist recommended a repeat study with diagnostic views. The conclusion of the two view x-ray for right wrist was no definite acute fracture, consider more sensitive imaging evaluation with CT as clinically directed. The physician was made aware with no new orders. Review of the February 2025 monthly physician orders identified orders dated 01/20/25 monitor scab to first digit to right hand daily until resolved, 01/21/25 maintain splint to right wrist, check placement and skin integrity every shift, non-weight bearing to right wrist, circulatory checks to right hand every shift, Review of the resident's progress notes revealed no documentation related to the increased edema and adjustment of the brace to the right wrist. On 02/04/25 at 10:01 A.M., observation/interview with the resident revealed he had a black orthotic splint to his right hand/wrist. He reported he fell on the ice at home and the hospital said it wasn't broken but he felt it was. He said his fingers bent back and touched his forearm. His right had was noted to be edematous around the the brace. The resident reported the brace felt tight. The resident denied having the brace adjusted. On 02/04/25 at 3:02 P.M., interview with Registered Nurse (RN) #111 confirmed the resident's orthotic splint to his right hand/wrist was too tight causing the swelling. Observation of the resident's right hand at the time of the interview revealed his right hand had doubled in swelling leaving indents of the orthotic brace in the back of his hand.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to ensure residents (#24, #50) were provided routine podiatry services. This affected two residents (#24, #50) of three residents review for activities of daily living (ADL). Findings Include: 1. Review of the medical record for Resident #24 revealed an initial admitted [DATE] with the latest readmission of 12/05/24 with the diagnoses including diabetes mellitus, polyneuropathy, spondylosis, disease of pancreas, gastro-esophageal reflux disease, osteoarthritis, disorders of urethra, obstructive and reflux uropathy, noncompliance with medical treatment and regimen, calculus of kidney, congestive heart failure, dysphagia, hypertension, anxiety disorder, atrial fibrillation, adjustment disorder with mixed disturbance of emotions and conduct, chronic pain syndrome, insomnia, major depressive disorder, basal cell carcinoma of skin of unspecified eyelid, acanthosis nigricans, hypothyroidism and hyperlipidemia. Review of the resident's plan of care dated 09/27/23 revealed the resident had self-care performance deficit related to muscle weakness, lack of coordination, need for assistance with personal care, stiffness of joints, atrial fibrillation and anxiety. Interventions included bilateral enables to bed, resident is to be upright for all meals, the resident requires two person assist with bathing, dressing, personal hygiene, toileting, transfers and supervision with eating, encourage participation in daily care and provide positive reinforcement for activities attempted and/or partially achieved, encourage resident to use call light when assistance is needed, honor resident's choices and preferences whenever possible, observe for pain during ADL tasks and report to nurse if observed, place assistive devices within reach, place call light within reach, provide cues and assist as needed to accomplish daily tasks, therapy to screen/evaluate/treat as needed, report changes in ADL abilities to Nurse, Physician/NP/PA, and/or Therapy and resident may utilize tilt and space wheelchair for locomotion. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident displayed verbal behaviors directed towards others. Review of the podiatry list for 11/01/24 and 01/08/25 revealed the resident was not seen by the podiatrist. Review of the resident's medical record revealed no documented evidence the resident refused podiatry care. On 02/03/25 at 10:55 A.M., observation of the resident's fingernails revealed the resident's right great toenail was long and curving under. On 02/05/25 at 12:55 P.M., interview with the resident revealed her left great toenail fell off while in the hospital and the right great toenail needed trimmed. (continued on next page)

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 1:02 P.M., interview with Regional Director of Clinical (RDC) #220 confirmed the resident was in need of podiatry of care. Review of the facility policy titled, Nail Care, (last revised 08/20/24) revealed the purpose of this procedure is to provide guidelines for the care of a resident's nails for good grooming and health. Routine cleaning and inspection of nails will be provided during activities of daily living (ADL) care on an ongoing basis. Routine nail care includes trimming and filing, will be provided on a regular basis and as the need arises. 28923 2. Review of Resident #50's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included neurocognitive disorder with Lewy Bodies, malignant neoplasm of unspecified breast, mood disorder, generalized anxiety disorder, depression, osteoarthritis of the bilateral hips, age-related cognitive decline, difficulty in walking, dementia, muscle weakness, lack of coordination, and need for assistance with personal care. Review of Resident #50's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had unclear speech. She was usually able to make herself understood and was usually able to understand others. Her cognition was severely impaired. She was not known to display any behaviors, nor was she known to reject care. She required partial/ moderate assist for personal hygiene. Review of Resident #50's care plans revealed the resident had a care plan in place for a self care performance deficit for activities of daily living (ADL's) related to neurocognitive disorder with Lewy bodies. There was nothing in the care plan regarding podiatry care. The resident's other active care plans did not address the need to provide podiatry services or assistance with trimming her toenails in any of the care plans in place for the resident. Review of Resident #50's physician's orders revealed there was not an order in place for the resident to receive any ancillary services to include podiatry services. Her physician's orders indicated she was placed under the care and services of hospice on 10/25/24 for senile degeneration of the brain. Further review of Resident #50's medical record revealed it was absent of any consents for ancillary services to include podiatry services. It was not clear if the resident and/ or her resident representative had been offered podiatry services, as one of the ancillary services offered by the facility, and had been declined. The medical record was absent of any podiatry consults that showed any podiatry services had been provided since the resident's admission to the facility on [DATE]. Review of facility provided lists of the contracted podiatrists prior visits revealed the podiatrist had been in the facility on 11/01/24 and again on 01/03/25. Resident #50 was not on either of those two lists to show podiatry services had been provided to the resident. On 02/03/25 at 10:52 A.M. an observation of Resident #50 noted her to be lying in bed with her feet uncovered. She was not wearing any socks or shoes and her toes were visible. The resident was noted to have a thick, long toenail on the great toe of the left foot. Her toenail on the right great toe was long as well but was not as thick as what the left side was. The toenails extended past the end of her digits and were growing out diagonally in the direction of her other toes. (continued on next page)

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Arbors at Pomeroy	36759 Rocksprings Road Pomeroy, OH 45769

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 8:20 A.M., an interview with Regional Director of Clinical Operations #220 revealed they had contacted the podiatrist that was contracted by the facility to see if Resident #50 had been seen by the podiatrist since her admission to the facility on [DATE]. They were waiting to hear back to see if the resident had been seen by the podiatrist during any of his previous visits. She was not able to obtain any additional information to show the resident had been seen. On 02/06/25 at 8:23 A.M., an interview with Registered Nurse (RN) #210 (who was the corporate office's senior DON assisting during the annual survey) revealed they were not able to find an ancillary service consent form for Resident #50 to determine if the resident/ resident representative wanted the resident to receive podiatry services while in the facility. They had no evidence that service was offered and declined by the resident or her representative. On 02/06/25 at 8:43 A.M., an interview with Certified Nursing Assistant (CNA) #145 revealed Resident #50 was a total assist for ADL's. The staff had to provide her with all personal hygiene care. She reported the resident liked to get her fingernails done. She was asked who was responsible for toenail care and indicated they were done by the podiatrist. She was asked if she had seen the resident's toenails lately and stated that she had not noticed them when she took care of her yesterday. She went to the resident's room and removed her socks. She confirmed the resident's toenails on both the great toes of her bilateral feet were long and growing out and sideways. She noted the toenail on the left great toe was also thick and her toenails were in need of being trimmed.

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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** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure fall prevention interventions were implemented for residents with a history of falls and another resident known to have non-pressure skin injuries had a footboard padded as per their plan of care. This affected three residents (#29, #37, and #50) of seven residents reviewed for accidents. Findings include: 1. Review of Resident #29's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included dementia with behavioral disturbances, unspecified psychosis, schizo-affective disorder, age-related cognitive decline, unsteadiness on her feet, lack of coordination, difficulty walking, and muscle weakness. Review of Resident #29's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and her cognition was moderately impaired. Hallucinations and delusions were noted. The resident had other behaviors director at others and was known to reject care. Substantial/ maximum assist was needed for bed mobility and transfers. She was identified as having had a fall since the last assessment that was without injury. Review of Resident #29's active care plans revealed she had a care plan in place for being at risk for falls related to bladder incontinence, bowel incontinence, functional problems, generalized weakness, impaired cognition with decreased safety awareness, needs assistance with activities of daily living (ADL's), and poor communication/comprehension. The care plan originated on 10/03/23. The goal was to reduce the risk of injury through the next review. Interventions included non-skid footwear to reduce the risk of slipping, as the resident allows (initiated 01/30/24), and for the bed to be in low position (initiated on 04/22/24). Review of Resident #29's physician's orders revealed the staff were to ensure the resident's bed was in low position unless providing care or when the resident was out of bed. That order was last ordered on 07/25/24. On 02/04/25 at 10:27 A.M., an observation of Resident #29 noted her to be in bed. Her bed was not in the lowest position as ordered or per her plan of care. On 02/05/25 at 1:20 P.M., further observations of Resident #29 noted her to be in bed resting on her side. Staff were not in her room providing care to the resident. Her bed frame was noted to be about 14 inches off the floor. The resident was also noted not to be wearing any non-skid socks for fall prevention as per her plan of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 1:25 P.M., an interview with Registered Nurse (RN) #147 revealed she did not consider Resident #29 to be at risk for falls due to the resident not getting up much anymore. She reported the resident was difficult to care for due to behaviors. She was usually more active at night, as she had her days and nights turned around. The resident had recent medication changes as they increased her Vistaril (an anti-anxiety medication) and put her back on Seroquel (an anti-psychotic medication). She was asked what fall prevention interventions were in place for the resident. She was not able to state what any of those were and indicated she would have to check the physician's orders and the resident's plan of care in the computer. She acknowledged the resident's fall prevention interventions included her bed to be in the lowest position and the resident was to have the use of non-skid socks to prevent her from slipping. She confirmed the resident's bed was not in its lowest position and the resident was not wearing non-skid socks. She was able to lower the bed about eight inches, until the bed frame was only six inches off the floor. She obtained a pair of non-skid socks from the resident's drawer under her wardrobe and put them on the resident's bare feet. 2. Review of Resident #50's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included history of a displaced intertrochanteric fracture of the right femur, neurocognitive disorder with Lewy Bodies, malignant neoplasm of unspecified breast, mood disorder, generalized anxiety disorder, osteoarthritis of the bilateral hips, age-related cognitive decline, difficulty in walking, dementia, muscle weakness, lack of coordination, age-related osteoporosis, and need for assistance with personal care. Review of Resident #50's significant change MDS assessment dated [DATE] revealed the resident had unclear speech. She was usually able to make herself understood and was usually able to understand others. Her vision was impaired with the use of corrective lenses. Her cognition was severely impaired, but she was not known to have any behaviors or rejection of care. Supervision or touching assist was needed with bed mobility and partial/ moderate assistance was needed with transfers. She was identified as having one fall with no injury that had occurred since her last assessment. Review of Resident #50's active care plans revealed she had a care plan in place for being at risk for falls/injury related to unspecified lack of coordination, dementia, and a history of a fracture to her right hip. The goal was to reduce the risk of injury through the next review. The interventions included the use of anti-rollbacks to her wheelchair (initiated on 10/25/24) and for gloves to be removed from the resident's room (07/11/24) related to a fall she had on 06/28/24. Review of Resident #50's progress notes revealed a nurse's note dated 06/28/24 at 3:05 P.M. that indicated the resident was heard yelling from her room and was found sitting on the floor on her buttocks. She was noted to have a glove on her left foot. Further review of Resident #50's progress notes revealed the resident suffered another fall on 10/14/24 at 5:25 P.M. when the staff noted the resident lying on the floor on her left side. She complained of bilateral hip pain and low back pain following the fall and was sent to the emergency room for an evaluation. She returned to the facility on [DATE] and anti-rollbacks were to be placed onto her wheelchair when available. On 02/05/25 at 11:00 A.M., Resident #50 was observed up in her wheelchair in the dining room attending an activity. The resident's wheelchair was noted to be missing the anti-rollback bar behind the right wheel of the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 11:05 A.M., an interview with Certified Nursing Assistant (CNA) #145 revealed Resident #50 was totally dependent on staff for care. She reported the resident had really went downhill, as of late. She was normally up in her wheelchair, but had been sleeping a lot lately. She considered the resident to be at risk for falls. The resident used to try to get up a lot and has fallen. When asked what fall prevention interventions were in place for the resident, she stated the resident had the use of a low bed. Fall mats were not being used at the bedside as they were more of a tripping hazard to the resident. She confirmed the resident had the use of a wheelchair and she was currently up in the dining room for an activity. She knew the resident had the use of a cushion when in her wheelchair but did not mention the use of an anti-rollback bars to her wheelchair. CNA #145 was asked to accompany the surveyor to the dining room to check to see what interventions were in place on the resident's wheelchair. She verified the resident only had one anti-rollback bar to her wheelchair and was missing the one on the right side of the wheelchair. Verification was made on 02/05/24 at 11:09 A.M. On 02/05/25 at 11:10 A.M., an interview with RN #147 revealed she was aware the resident was up in her wheelchair and in the dining room for an activity. She denied she was aware the resident's wheelchair was missing one of the two anti-rollback bars to the back of her wheelchair. She knew the resident was supposed to have those on the back of her wheelchair. She was asked to clarify the care plan intervention for no gloves in the resident's room. She stated she was unaware of that being a fall prevention intervention for the resident. She did recall the resident had a fall in the past that involved her putting a disposable glove over her foot that was deemed to be a contributing factor to one of her falls. She verified the resident had two boxes of disposable gloves in her room that were above the sink. She asked where that was in the resident's record that indicated she was not to have gloves in her room. She was made aware that was one of the fall prevention interventions on her plan of care. She removed the two boxes from the resident's room at that time. Review of the facility's policy on Fall Prevention Program (revised 01/01/22) revealed each resident would be assessed for the risk of falling and would receive care and services in accordance with the level of risk to minimize the likelihood of falls. Each resident's risk factors and environmental hazards would be evaluated when developing the resident's comprehensive plan of care. Interventions would be monitored for effectiveness and the plan of care would be revised as needed. 32654 3. Review of the medical record for Resident #37 revealed an initial admitted [DATE] with the latest readmission of 08/01/24 with the diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, diabetes mellitus, anxiety disorder, hypertension, dysphagia, insomnia, schizoaffective disorder, constipation, hyperlipidemia, gastro-esophageal reflux disease, hearing loss, depression, peripheral vascular disease, and idiopathic peripheral autonomic neuropathy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 09/27/23 revealed the resident had impaired skin integrity as evidenced by scabs to right dorsum foot second digit and scabs to rear right thigh. Interventions included padded foot board, circulation checks as ordered, encourage resident to keep arms inside wheelchair when going through doorways, encourage resident to wear pants before getting out of bed, resident/family education provided for safe transfers, administer medication/treatments as ordered, apply protective barrier cream after incontinent episode, assist resident with turning and repositioning as needed, complete skin inspection weekly and as needed, consult Dietitian as needed, encourage good nutrition and hydration, assist as needed, encourage/assist as needed to elevate heels off the mattress as tolerated, if resident refuses interventions/treatments, encourage compliance to minimize further skin impairment, labs as ordered, notify nurse of any new areas of skin impairment noted during bathing or daily care, notify Physician/NP/PA of noted worsening skin condition or any new areas of skin impairment, notify Physician/NP/PA of signs/symptoms of infection, pressure redistribution mattress to bed and therapy screen/evaluation/treat as needed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident rejected care. The assessment indicated the resident was at risk for skin breakdown and had no skin issues. Review of the monthly physician orders for February 2025 identified an order dated 08/01/24 padded footboard to prevent further skin injuries. On 02/04/25 at 9:36 A.M., observation of the resident's footboard was not padded as physician ordered. On 02/05/25 at 2:26 P.M., interview with Licensed Practical Nurse (LPN) #144 confirmed the resident's footboard was not padded as physician ordered.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and facility policy review, the facility failed to address a pharmacy recommendation timely for one resident (#24). Additionally, the physician failed to provide a rationale for the decline of a pharmacy recommended gradual dose reduction (GDR) for Resident #5. This affected two residents (#5, #24) of five residents reviewed for unnecessary medications. Findings Include: 1. Review of the medical record for Resident #5 revealed an initial admitted [DATE] with the latest readmission of 12/26/23 with the diagnoses including but not limited to cerebrovascular accident (CVA) with right sided hemiplegia, chronic obstructive pulmonary disease (COPD), aphasia, mild intellectual disabilities, dysphagia, idiopathic peripheral autonomic neuropathy, vertigo, protein calorie malnutrition, schizophrenia, bipolar disorder, osteoporosis, hyperlipidemia, peripheral vascular disease, cerebellar ataxia, hypertension, malignant neoplasm of prostate, solitary pulmonary nodule, dementia with agitation, major depressive disorder, benign prostatic hyperplasia, alcohol abuse and nicotine dependence. Review of the plan of care dated 12/01/23 revealed the resident took psychotropic/mood stabilizer medication as evidenced by antidepressant use, antipsychotic use and Mirtazapine use. Interventions included administer medications as ordered, consult with Pharmacist/Physician/NP/PA for gradual dose reduction if appropriate, observe PHQ-9 score for indication of worsening signs/symptoms of depression, refer to psychologist/psychiatrist as needed, review with resident/family/responsible person the risks vs. benefits of psychotropic medication use, observe for and report to Physician/NP/PA adverse effects of antidepressant medication use, observe for and report to Physician/NP/PA adverse effects of antipsychotic/mood stabilizer medication use and periodically complete the AIMS evaluation for extrapyramidal symptoms. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated the dementia, depression, bipolar disorder and schizophrenia were current diagnoses. The resident received antipsychotic and opioid medications. The resident received antipsychotic medication on a routine basis, a GDR had not been attempted and and the physician had not documented the GDR was not clinically contraindicated. Review of the resident's AIMS scale dated 12/25/24 revealed a score of zero indicating the resident had no abnormal involuntary movements. Review of the monthly physician orders for February 2025 identified orders dated 01/03/24 Depakote Sprinkles 375 mg by mouth twice daily, 01/15/24 Risperdal 0.25 milligrams (mg) by mouth two times a day and Risperdal 0.5 mg by mouth daily and 01/23/24 Remeron 7.5 mg by mouth daily at bedtime for appetite stimulant. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy recommendation dated 06/26/24 revealed the pharmacist recommended a GDR for the medication Remeron used as an appetite stimulant. The physician addressed on 07/02/24 and documented continue as ordered. No explanation for the continued use of the medication was documented. Review of the pharmacy recommendation dated 01/27/24 revealed the pharmacist recommended a GDR on the medications Depakote Sprinkles 375 mg by mouth twice daily, Remeron 7.5 mg by mouth daily at bedtime for appetite stimulant and Risperdal 0.25 mg twice daily and Risperdal 0.5 mg by mouth daily. The physician addressed the recommendation on 02/03/25 and checked the resident had a good response, maintain the current dose and to see the physician progress note. Review of the resident's medical record revealed no progress note dated 02/03/25 indicating a rationale to decline the recommended GDR. On 02/06/25 at 1:52 P.M., interview with the Director of Nursing (DON) confirmed no rationale for the decline for the 06/26/24 and 01/27/25 pharmacy recommendations. 2. Review of the medical record for Resident #24 revealed an initial admitted [DATE] with the latest readmission of 12/05/24 with the diagnoses including diabetes mellitus, polyneuropathy, spondylosis, disease of pancreas, gastro-esophageal reflux disease, osteoarthritis, disorders of urethra, obstructive and reflux uropathy, noncompliance with medical treatment and regimen, calculus of kidney, congestive heart failure, dysphagia, hypertension, anxiety disorder, atrial fibrillation, adjustment disorder with mixed disturbance of emotions and conduct, chronic pain syndrome, insomnia, major depressive disorder, basal cell carcinoma of skin of unspecified eyelid, acanthosis nigricans, hypothyroidism and hyperlipidemia. Review of the plan of care dated 02/01/24 revealed the resident takes psychotropic/mood stabilizer medication as evidenced by antianxiety use. Interventions included administer medications as ordered, consult with Pharmacist/Physician/Nurse Practitioner (NP)/Physician Assistant (PA) for gradual dose reduction if appropriate, observe PHQ-9 score for indication of worsening signs/symptoms of depression, refer to psychologist/psychiatrist as needed, review with resident/family/responsible person the risks vs. benefits of psychotropic medication use and Monitor for and report to Physician/NP/PA adverse effects of antianxiety medication use. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident displayed verbal behaviors directed towards others. The assessment indicated anxiety disorder and depression were current diagnoses. The resident received daily insulin injections, antianxiety, antidepressant, anticoagulant, diuretic, antiplatelet, opioid and hypoglycemic medications. Review of the resident's monthly physician orders for February 2025 identified orders dated 12/04/24 Buspar 5 mg by mouth two times a day for anxiety Review of the medical record revealed the facility contracted pharmacist reviewed the resident's drug regimen monthly and made recommendations as applicable. Review of the pharmacy recommendation dated 03/12/24 revealed the pharmacist recommended a reduction on the medication Omeprazole 20 mg twice daily. The physician agreed with the recommendation on 05/01/24 and decreased the medication to 20 mg daily. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 12:42 P.M., interview with Regional Director of Clinical (RDC) #220 verified the recommendation was addressed more than 30 days after the recommendation was made and should have been addressed within 30 days. Review of the facility policy titled, Addressing Medication Regimen Review Irregularities, (last revised 12/28/23) revealed it was the policy of the facility to provide a medication regimen review (MRR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on medical record review and interview the facility failed to obtain physician ordered laboratory testing for one resident (#45) of five sampled for unnecessary medications. The facility census was 66. Findings include: Review of Resident #45's medical record revealed an admitted [DATE] and diagnoses including Alzheimer's disease, Crohn's disease, dementia, delusional disorders, hallucinations, unspecified psychosis, anxiety disorder, and depression. Review of Resident #45's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status score of 03 indicating a severe cognitive deficit. Further review revealed Resident #45 had hallucinations in the seven days prior to the MDS date of 10/29/24. Further review of the MDS revealed Resident #45 had received antipsychotic and antidepressant medications in the seven days prior to the MDS date of 10/29/24. Review of the pharmacy recommendation note to attending physician/prescriber dated 07/25/24 revealed Resident #45 was receiving respiridone and quentiapine and that these medications had a risk of causing adverse metabolic effects. The pharmacy recommended checking a fasting lipid panel, a fasting glucose level and an A1C (a blood test that measures a persons average blood sugar/glucose levels over the past two to three months) yearly. Review of Resident #45's physician's orders revealed an order dated 07/29/24 to check Resident #45's A1C yearly. Further review of Resident #45's medical record revealed no A1C results. Interview on 02/06/25 at 10:30 A.M. the facility Director of Nursing, Registered Nurse #151 confirmed the facility did not have A1C results for Resident #45.