

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Arbors at Pomeroy		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident's comprehensive care plans addressed the resident's known problem with constipation related to a malignant neoplasm of the colon, use of opioid pain medication, and receiving stool softeners/ laxatives on a scheduled basis for constipation. This affected one (Resident #55) of 23 residents reviewed for care plans. Findings include: Review of Resident #55's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included a malignant neoplasm of the colon, morbid obesity, chronic pain, and muscle weakness. Review of Resident #55's active physician's orders revealed the resident had orders in place to receive Colace (a stool softener) 100 milligrams (mg) with directions to give two capsules by mouth (po) two times a day for constipation. The order originated on 03/28/26. She was also to receive Lactulose (a laxative) 10 grams/ 15 milliliters (ml) with directions to receive 15 ml po once daily for constipation. That order originated on 03/23/26. She also had an order for Norco (narcotic pain medication) 7.5- 325 mg po every six hours as needed (prn) for chronic pain. She had been receiving that medication on a prn basis, since 07/07/26. Review of Resident #55's medication administration record (MAR) for July 2026 revealed the resident was receiving her Colace and Lactulose on a scheduled basis, as ordered for constipation. She was receiving Norco 7.5- 325 mg prn for pain, as ordered. Review of Resident #55's active care plans revealed she did not have a care plan in place to address her known constipation, despite the use of stool softeners/ laxatives on a scheduled basis for the treatment of constipation, her known diagnosis of malignant neoplasm of the colon that put her at risk for constipation, or the use of an opioid pain medication that had constipation as a potential side effect of the medication. On 07/15/26 at 10:30 A.M., an interview with Registered Nurse (RN) #184 confirmed Resident #55's active care plans did not address constipation, as one of the resident's medical problems. She acknowledged, with the resident's medical diagnoses and the use of medications to treat constipation on a scheduled basis, the resident should have had an active care plan addressing that medical problem. Review of the facility's policy on Comprehensive Care Plans 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 included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment (Minimum Data Set assessment). The comprehensive care plan would describe, at a minimum, the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 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** Based on record review, resident interview, and staff interview, the facility failed to ensure a resident received the appropriate medications, in accordance with his physician's orders, to properly manage/ treat his known chronic diarrhea. This affected one (Resident #9) of one residents reviewed for constipation/ diarrhea. Findings include: Review of Resident #9's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a malignant neoplasm of the prostate and the need for assistance with personal care. He was hospitalized on [DATE] and readmitted to the facility on [DATE], after being treated for pneumonia and a urinary tract infection. Review of Resident #9's physician's orders revealed the resident was receiving Lomotil (an antidiarrheal used to treat severe or chronic diarrhea) 2.5 milligrams (mg)- 0.025 mg by mouth (po) three times a day for chronic diarrhea. He had been on that medication since 01/28/26. He was also receiving Glycolax (an osmotic laxative used to treat occasional constipation) 17 grams po once daily for constipation. That order originated on 07/05/26. He also had an order for Imodium (an antidiarrheal) 2 mg with directions to give one tablet by mouth prn for loose stools with directions to take one tablet after each loose stool, maximum of eight tabs/24 hours. Review of Resident #9's medication administration record (MAR) for July 2026 revealed the resident was receiving Lomotil 2.5 mg- 0.025 mg po three times a day on a scheduled basis, as ordered for chronic diarrhea. He was also receiving Glycolax 17 grams po once daily on a scheduled basis for constipation, since his return from the hospital on [DATE]. He had not received any doses of Imodium that was ordered to be given on an as needed basis for loose stools/ diarrhea. Review of Resident #9's Discharge Instructions included in his hospital paperwork for his hospitalization between 07/02/26 and 07/05/26 revealed he was to start taking Clearlax (another brand name for Glycolax/ Miralax) 17 grams one packet by mouth once daily as needed (prn) for constipation. He was not to receive the Clearlax 17 grams once daily on a scheduled basis, as was written and being administered to the resident since his return from the hospital on [DATE]. Review of Resident #9's bowel movement (BM) report for the past 30 days (06/17/26- 07/16/26) revealed the resident was documented as having diarrhea 13 times in the past 30 days. Since his return from the hospital on [DATE], the resident was documented as having diarrhea on 07/05/26, 07/06/26, 07/10/26, 07/11/26, 07/12/26, 07/13/26, 07/15/26, and 07/16/26. On 07/13/2026 at 10:23 A.M., an interview with Resident #9 revealed he has been having diarrhea that he felt the facility was not adequately addressing. He reported they have been giving him something for diarrhea but it did not seem to be helping. He was not sure what all medications he was receiving for that but confirmed he continued to have diarrhea, since returning from the hospital. On 07/16/26 at 10:55 A.M., findings were verified by RN #184 that Resident #9 was receiving both Lomotil three times a day on a scheduled basis for chronic diarrhea and also Glycolax 17 grams po daily for constipation. She agreed it did not make sense for the resident to be receiving one medication for chronic diarrhea and the other for constipation. She confirmed Resident #9's hospital discharge orders for 07/05/26 intended the Glycolax to be used once daily prn for constipation and not on a scheduled basis, as erroneously transcribed upon his return from the hospital. She acknowledged the resident was complaining of loose stools and his BM report showed he was still having loose stools/ diarrhea on multiple days, since returning from the hospital on [DATE]. She further confirmed the facility's MAR for July 2026 did not show the resident had been given any prn doses of Imodium that was ordered to be given as needed for diarrhea.		

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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** Based on record review, observations, and interview, the facility failed to ensure fall prevention interventions were in place per the plan of care for Resident #8 and #33. The facility also failed to ensure additional safety interventions were in place for seizure precautions and hot beverages for Resident #8. This affected two (#8 and #33) of three residents reviewed for accidents. The facility census was 66. Findings include: 1. Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including dementia, epilepsy, and difficulty in walking. Review of the minimum data set (MDS) dated [DATE] revealed Resident #8's cognition was moderately impaired and she had no falls. a. Review of orders revealed Resident #8 had an order in place dated 02/17/25 to encourage lids to hot liquids. Review of a care plan updated on 06/18/26 revealed Resident #8 was at risk for falls/injury related to unsteady gait and difficulty with coordination. The goal was to reduce the risk of injury through the next review date. Interventions included but were not limited to encourage resident to use a cup with lid when handling hot liquids and visual cue to ask for assistance. Observation on 07/13/26 at 3:26 P.M. revealed Resident #8 was resting in bed and had a cup of coffee on her bedside table. There was no lid on the coffee. Observation on 07/16/26 at 8:03 A.M. with Registered Nurse (RN) #163 confirmed Resident #8 was in bed having breakfast and there was no lid on her cup of coffee. RN #163 confirmed there was an order in place for Resident #8 to be encouraged to use a lid with hot beverages. Observation on 07/16/26 at 2:30 P.M. revealed there was no sign in Resident #8's room as a visual cue to ask for assistance. Interview during this time with Certified Nursing Assistant (CNA) #180 confirmed there was no visual cue in Resident #8's room. CNA #180 stated Resident #8 had a room change a couple weeks ago and the sign was likely left behind. b. Review of an orders revealed an order for Resident #8 dated 07/12/26 to have padding to enabler rails related to seizure precautions. Observation on 07/13/26 at 3:26 P.M. revealed Resident #8 was resting in bed and there was no padding to her enabler rails. Observation on 07/14/26 at 2:40 P.M. revealed Resident #8 was resting in bed and had no padding to her enabler rails for seizure precaution. Interview with Activity Director (AD) #116 and RN #129 confirmed there was no padding to the enabler rails. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #66's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included dementia, anxiety disorder, a history of a stroke, adult-onset diabetes mellitus, hypertension, age-related osteoporosis, muscle weakness, unsteadiness on feet, and irritable bowel syndrome. Review of Resident #66's active care plans revealed the resident had a care plan in place for being at risk for falls and injury related to her history of a stroke, impaired cognition, and impulsiveness. The care plan originated on 12/01/25. The goal was to reduce the risk of injury through the next review date. The interventions included the need for a low bed when not providing care and for the use of floor mats at bedside. The intervention for the low bed had been in place since 12/15/25. Review of Resident #66's active physician's orders revealed the resident had an order to be in a low bed while in bed and staff were to check every shift. That order originated on 02/10/26. On 07/14/2026 at 9:02 A.M., an observation of Resident #66 noted her to be lying in bed with her upper torso leaning to the left side of the bed. She had fall mats on the floor on each side of the bed, but her bed was not in it's lowest position. On 07/14/26 at 4:15 P.M., a follow up observation of Resident #66 noted her to be again, in bed, after she had been previously observed up in her wheelchair in the dining room for lunch. She had her fall mats on the floor on both sides of the bed, but her bed was raised and not in it's lowest position and she was not receiving any care by staff. The resident's bedframe was approximately 14 inches off the floor and the top level of the mattress was approximately 22 inches off the floor. On 07/14/26 at 4:33 P.M., an interview with RN #129 revealed Resident #66 was considered to be at risk for falls. She denied the resident had any recent falls, but had fallen in the past when trying to self-transfer. She reported the resident's fall prevention interventions included the use of fall mats on the floor, when in bed, and the resident was to be in a low bed. She confirmed the resident was lying in bed and her bed was not in it's lowest position. She lowered the resident's bed so the bedframe was only approximately eight inches off the floor and the level of the top of the mattress was only 16 inches off the floor. She acknowledged several observations had been made of the resident being in bed, without the bed being in it's lowest position, and would be at greater risk of injuries from a fall, if she rolled out of bed. Review of the facility's Fall Prevention Program policy revised 10/26/23 revealed each resident would be assessed for the risks of falling and would receive care and services in accordance with the level of risk to minimize the likelihood of falls. The nurse would indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of fall risk. 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.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were not administered outside of physician ordered parameters. This affected one Resident (#4) of five sampled for unnecessary medication use. The facility census was 66. Findings include: Review of Resident #4's medical record revealed an admission date of 12/27/21 with diagnoses including transient cerebral ischemic attack (mini-stroke), and hypertension (high blood pressure). Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment and hypertension. Review of Resident #4's physician orders revealed an order dated 05/01/26 for metoprolol succinate tablet extended release 50 milligrams give 0.5 tablet by mouth one time a day for hypertension. Hold for systolic blood pressure (SBP) (the top number of the blood pressure reading) less than 100 millimeters (mm) of mercury (Hg) or diastolic blood pressure (the bottom number of the blood pressure reading) less than 80 mm Hg, or a heart rate (HR) less than 60 beats per minute. Review of Resident #4's July 2026 medication administration record (MAR) revealed the medication was administered despite a diastolic blood pressure reading of less than 80 mm Hg on 07/04/26 BP 144/77 mmHg, 07/06/26 BP 134/68 mmHg, 07/07/26 BP 130/75 mmHg, 07/08/26 BP 140/72 mmHg, 07/12/26 BP 140/76 mmHg, 07/13/26 BP 116/70 mmHg, 07/14/26 BP 141/72 mmHg and 07/15/26 BP 146/77 mmHg. In an interview on 07/15/2026 at 3:55 P.M. Regional Nurse #184 confirmed the metoprolol was not held according to the ordered parameters, when the diastolic blood pressure was less than 80 mmHg on 07/04/26, 07/06/26, 07/07/26, 07/08/26, 07/12/26, 07/13/26, 07/14/26 and 07/15/26. The Regional Nurse confirmed the metoprolol should not have been administered.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, review of the facility's spreadsheet for therapeutic menus, interview, and policy review, the facility failed to ensure a resident received all food items included on the menu for their ordered therapeutic diet. This affected one (Resident #71) of one residents, who the facility identified as being on a renal diet. Findings include: Review of Resident #71's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included end stage renal (kidney) disease and dependence on renal dialysis (life saving medical treatment that filters waste, excess salt and fluid from a person's blood when the kidneys no longer function properly). Review of Resident #71's active physician's orders revealed the resident was on a renal (chronic kidney disease 5) diet. The order originated on 07/14/26, when the resident was readmitted from the hospital. On 07/15/26 at 12:02 P.M., an observation of the tray line process for the lunch meal served revealed Resident #71's meal ticket came through that identified the resident as being on a renal diet. The cook (Dietary [NAME] #138) and the dietary aide (Dietary Aide #152) used the meal ticket to identify what food items the resident was to receive for that meal. The cook substituted a baked potato that was given to the majority of residents with buttered noodles, as per the renal diet menu. The resident was not provided a piece of cornbread that the majority of other residents received. Dietary Aide #152 was observed to initially place a piece of cornbread on Resident #71's tray but then removed it, without putting any other type of bread item on her tray. There was a bowl that contained pre-wrapped cornbread in it and there were no other bread options available for the meal service, as part of the tray line. Review of the facility's spreadsheet for all diets (including the therapeutic diets) revealed the residents on a renal diet were to have buttered noodles substituted in place of a baked potato, which Resident #71 did receive. The renal diet menu also indicated the residents on that diet were not to receive cornbread, but should have been provided with a dinner roll or a slice of bread in place of the omitted cornbread from their diet. On 07/15/26 at 1:25 P.M., an interview with Dietary Manager #101 confirmed Resident #71 was on a renal diet at the time of the meal service being observed. She acknowledged Resident #71 was not provided with a dinner roll or a slice of bread in place of cornbread, as specified on the renal diet spreadsheet. She further acknowledged Dietary Aide #152 initially put a piece of cornbread on Resident #71's tray that was not permitted before removing it and not replacing it with any other bread source (dinner roll/ slice of bread) that was permitted based on the resident's diet menu. On 07/15/26 at 1:45 P.M., an interview with Resident #71 confirmed she did not receive a dinner roll or a slice of bread with her lunch, as was included on the renal diet menu. She stated she would have liked to have had a dinner roll to help fill her up. She did not like the noodles that were provided to her and did not care for the chicken that was served. The dinner roll would have allowed her something to eat, if it had been offered. Review of the facility's policy on Therapeutic Diet Orders revised 07/01/25 revealed the facility was to provide all residents with food in the appropriate form and/ or the appropriate nutritive content as prescribed by a physician, and/ or assessed by the interdisciplinary team to support the resident's treatment/ plan of care, in accordance with his/ her goals and preferences. A therapeutic diet was defined as a diet ordered by a physician, or delegated registered or licensed dietitian, as part of treatment for a disease or clinical condition. It also may be ordered to eliminate, decrease, or increase specific nutrients in the diet. Therapeutic diets would be based on the resident's individual needs as determined by the resident's assessment. Dietary and nursing staff were responsible for providing therapeutic diets in the appropriate form and/ or the appropriate nutritive content as prescribed.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and policy review, the facility failed to ensure residents had assistive devices in place for meals. This affected one (#33) of one resident reviewed for assistive devices. The facility census was 66. Findings include:Record review revealed Resident #33 admitted to the facility on [DATE] with diagnoses including Parkinsonism, dementia, and need for assistance with personal care.Review of a Minimum Data Set (MDS) Assessment completed 05/07/26 revealed Resident #33's cognition was mildly impaired.Review of physician orders revealed Resident #33 had an order in place dated 05/15/26 for a regular diet with level three texture, regular fluid, thin consistency, drink one electrolyte daily, weighted utensils and plate guard to be used with each meal, Sippy cup (a spouted lid to aid in drinking) with each meal, and double bread for breakfast.Review of a care plan revised on 07/13/26 revealed Resident #33 was at risk for altered nutritional status related to mechanically altered diet, medical diagnosis of Parkinsonism, hypotension, dementia, hypertension, hyperlipidemia, depression, and a history of weight loss. Resident #33 required a sippy cup and weighted utensils. The goal was to maintain nutritional status as evidenced by stable weight without significant changes through the next review. Interventions included but were not limited to provide adaptive equipment.Observation on 07/16/26 at 8:02 A.M. revealed Certified Nursing Assistant (CNA) #177 was in Resident #33's room assisting him with breakfast. CNA #177 stated Resident #33 had a glass of juice with a straw to make it easier because he is shaky. There was no sippy or spouted cup observed for use during the meal.Interview on 07/16/26 at 8:03 A.M. with Registered Nurse (RN) #163 confirmed Resident #33 had an order in place for a sippy cup/cup with spouted lid for all meals as an assistive device during meals.Review of a policy titled Use of Assistive Devices dated 10/26/23 revealed assistive devices are tools, products, types of equipment, or technology to help individuals perform tasks and activities to help move around, see, communicate, eat, or get dressed. The facility will provide assistive devices for residents who need them. Assistive devices helps to maintain or improve function and/or dignity.		