STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365523	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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 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. Based on medical record review, staff interview, and review of the facility policy the facility failed to ensure wound measurements were completed for ongoing assessment of wounds. This affected one (#64) of three residents reviewed for wound care. The facility census was 66. Findings include:Review of Resident #64's medical record revealed an admission date of 12/28/23. Diagnoses included diabetes mellitus, portal hypertension, transient ischemic attack (TIA), congestive heart failure, end stage renal disease, and dependence on renal dialysis.Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/15/25, revealed Resident #64 had a diabetic foot ulcer.Review of the current physician orders for August 2025 revealed Resident #64 had a treatment order for a diabetic foot ulcer to the right plantar foot to cleanse the wound with wound cleaner, apply medihoney to the wound bed, then apply adaptic (non-stick moist dressing), and cover with abdominal pad and wrap in kerlix daily.Review of the care plan, revised July 2025, revealed Resident #64 had a diabetic foot ulcer with interventions in place to complete wound treatment as prescribed.Review of the skin and wound assessments from 06/16/25 through 07/28/25 revealed no measurements of Resident #64's diabetic wound. Interview on 08/13/25 at 10:44 A.M. with Registered Nurse (RN) #551 verified Resident #64's wound was not measured from 06/16/25 through 07/28/25.Review of the facility policy titled, Wound Treatment Management, revised October 2023, revealed to promote the healing of various types of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current wound standards of practice and physician orders. The effectiveness of treatments would be monitored through ongoing assessment of the wound and considerations for needed modifications. This deficiency represents non-compliance investigated under Complaint Number 2568913.

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a social media post, medical record review, staff interview, Police Detective (PD) interview, review of the facility video surveillance, review of the Local Police Department (LPD) report, review of the local weather report and review of the facility policy, the facility failed to ensure Resident #23, who had a diagnosis of alcohol dependence with induced persisting dementia, had a history of an elopement from a previous facility, was assessed to be at risk for elopement, and had a Wanderguard (wearable bracelet that triggers alarms at the doors to alert staff when a resident attempts to exit) applied to his left ankle, did not elope from the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injury, and/or death on 08/09/25 at 10:38 A.M. when Resident #23 removed his Wanderguard and was able to exit through the front door of the facility. Facility staff were unaware Resident #23 was missing until 08/10/25 at approximately 2:00 A.M. (about 15.5 hours after the resident eloped). Furthermore, Resident #23 was missing for approximately 52 hours before facility staff, who were driving around the local area searching for the resident, found the resident at a bus stop, approximately three miles from the facility. This affected one (#23) of three residents reviewed for elopement. The facility identified six (#14, #22, #23, #28, #34, and #44) residents at risk for elopement. The facility census was 66.On 08/09/25 at 3:02 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 08/09/25 at 10:38 A.M. when Resident #23, who had removed his Wanderguard, was able to exit out of the front door without staff knowledge. Resident #23 ambulated through the parking lot and crossed a moderately traveled two lane road with a speed limit of 35 miles per hour (MPH) before the resident could no longer been seen on the video camera. Facility staff confused Resident #23 with another resident of the facility and did not identify that Resident #23 was missing until 08/10/25 at approximately 2:00 A.M., nearly 15.5 hours after Resident #23 eloped. Resident #23 was not located until 08/11/25 at 2:32 P.M., when facility staff found the resident at a public bus stop. The route traveled by Resident #23 was unknown; however, the area surrounding the facility included heavily traveled four lane roads with speed limits of 40 to 45 MPH and a major interstate highway with speed limits of 60 to 65 MPH. During the time that Resident #23 was missing, it was unknown where he stayed, how he obtained food or hydration, and high temperatures in the area ranged from 90 degrees Fahrenheit (F) on 08/09/25 to 91 degrees F on 08/10/25 and 08/11/25.The Immediate Jeopardy was removed 08/11/25, when the facility implemented the following corrective action plan: On 08/10/25, the DON or designee educated licensed and non-licensed nursing staff on checking assignments prior to starting their shift for assignment location, nurse and Certified Nursing Assistants (CNAs) assigned to the hall, validating residents' identity utilizing photographs in the electronic medical record (EMR), the facility's Leave of Absence (LOA) policy, and the elopement policy. On 8/10/25, the DON reassessed all residents for elopement risk to ensure accuracy of assessments and care plans were reviewed and updated as needed to ensure adequate interventions were in place. On 08/10/25, the DON completed a visual audit of all residents with orders for a Wanderguard to ensure placement, with no concerns identified. On 08/10/25, the DON or designee completed an elopement drill on each shift at the facility, with no concerns identified. On 08/11/25 at 2:32 P.M., Regional Director of Operations (RDO) #603 located Resident #23 in downtown [NAME] at a public bus hub, approximately three miles from the facility. Regional Director of Clinical Services (RDCS) #604 contacted the local police department (LPD) at 2:34 P.M. for assistance. Emergency Medical Services (EMS) and the LPD responded. EMS assessed Resident #23 and medically cleared him to return to the facility. Resident #23 was transported back to the facility by PD #600. On 08/11/25 at approximately 3:15 P.M, Resident #23 returned to the facility and was placed on one-to-one (1:1) staff supervision to ensure his safety. Resident #23 will remain on 1:1 staff supervision until a more appropriate placement can be found. Registered Nurse (RN) #583 assessed Resident #23 and notified his responsible party and attending physician of his return. On 08/11/25, the DON reassessed Resident #23 for elopement risk, which remained at high risk, and the resident's care plan was reviewed and updated, to include continuous 1:1 staff supervision. On 08/11/25, the Administrator and DON completed a root cause analysis and determined Resident #23 likely removed his Wanderguard by using the blades from disposable razors to cut through the band, allowing the resident to exit through the front door of the facility without activating the alarms and locking the door. Additionally, staff failed to complete proper and accurate communication to ensure Resident #23, who was assessed to be at risk for elopement and had a

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure medication carts were secured when left unattended and further failed to appropriately dispose of oral syringes used for the administration of medication. This had the potential to affect seven (#22, #23, #28, #31, #34,#35, and #44) residents identified by the facility as being cognitively impaired, independently mobile, and resided on the C and D Halls. The facility census was 66. Findings include:Observation on 08/06/25 at 7:00 A.M., upon entry into the facility, revealed an unattended and unlocked medication cart near the beginning of the C and D Halls. On top of the medication cart was a clear plastic drinking cup that contained two small oral syringes (no needle attached), resembling the type of syringe that was used to administer liquid oral medications. Small droplets of an unknown clear substance were observed on the syringes and on the inside of the drinking cup. No facility staff were observed in the area. Continuous observation revealed at 7:05 A.M., Licensed Practical Nurse (LPN) #505 exited a resident's room, from behind a closed door, at the very end of the D Hall. Further observation revealed the D Hall had 13 resident rooms, a shower room, a soiled linen utility room, and other office type rooms. Interview on 08/06/25 at 7:05 A.M. with LPN #505 verified the medication cart was left unlocked and unattended. LPN #505 further confirmed the two syringes in the clear drinking cup on top of the medication cart had been used to administer morphine sulphate. LPN #505 stated this was not her medication cart and she was trying to clean up the mess left by night shift. LPN #505 verified shift change was at 6:00 A.M. (approximately one hour prior). Review of the facility policy titled, Medication Storage, revised January 2024, revealed it was the policy of the facility to ensure all medications housed on the premises would be stored according to the manufacturer's recommendations and ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. During a medication pass, medications would be under direct observation of the person administering medications or locked in the medication storage area or cart. This deficiency was an incidental finding discovered during the complaint investigation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of the facility policy the facility failed to ensure foods were appropriately stored and further failed to ensure foods were discarded of past the use by dates. This had the potential to affect all residents residing in the facility, except for 13 (#3, #5, #6, #8, #12, #13, #15, #16, #17, #19, #20, #21, and #33) residents identified by the facility as receiving no food by mouth. The facility census was 66.Findings include:Observations on 08/06/25 from 7:20 A.M. to 7:42 A.M. of the kitchen revealed the milk cooler contained a crate holding 38 individual cartons of one percent milk with a stamped expiration date of 08/05/25, two unopened thickened orange juice containers with an expiration date of February 2024, and one unopened thickened apple juice with an expiration date of July 2025. Interview on 08/06/25 at 8:22 A.M. with Dietary Manager (DM) #541 verified the expired thickened orange juice, apple juice, and one percent milk. Observation on 08/06/25 at 8:25 A.M. of the east pantry (where the refrigerator was located to hold foods brought in by residents and/or family and visitors) revealed a bag containing food from a fast-food restaurant that was not labeled with a name and was dated 07/25/25; a container of potato salad, unlabeled with a name and dated 06/17/25; and food debris of cheese, lettuce, and croutons on the floor in front of the refrigerator. Concurrent interview with Licensed Practical Nurse (LPN) #506 verified the findings.Interview on 08/06/25 at 8:25 A.M. with DM #541 revealed dietary staff maintained the temperature logs for the pantry refrigerator and cleaned the refrigerator maybe two to three times per month but all staff were responsible for maintaining the refrigerator.Observation on 08/06/25 at 8:30 A.M. of the west pantry revealed an unlabeled plastic grocery bag of unknown food dated 07/04/25, one plastic grocery bag of unknown food unlabeled and undated, two different restaurant boxes that contained food that were undated, and an expired carton of milk that was dated 08/03/25. Concurrent interview with Medical Records Clerk (MRC) #561 verified the findings. Review of the facility policy title, Food Receiving and Storage revised July 2025, revealed foods should be received and stored in a manner that complied with safe food handling practices. All dry foods were labeled, dated, and rotated by using the first in-first out system. All foods stored in the refrigerator would be covered, labeled and dated. Review of the facility policy titled, Use and Storage of Food Brought in by Family or Visitor, revised July 2025, revealed family members and visitors may bring the resident food of their choosing. All food items that were already prepared by the family or visitor must be labeled with the contents and dated. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. Food must be consumed by the resident within three days and, if not consumed within three days, the food would be thrown away by the facility staff. This deficiency represents non-compliance investigated under Complaint Number 1260630 and Complaint Number 1260631.