STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365687	A. Building B. Wing	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Marietta	400 Seventh Street Marietta, OH 45750

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on record review, facility policy and procedure review and interview the facility failed to ensure an incident of potential misappropriation of narcotics was investigated. This affected one resident (#69) of three residents reviewed for medication errors. Findings include: Review of Resident #69's medical record revealed an admitted [DATE] with diagnoses including adult failure to thrive and Alzheimer's Disease. Review of the physician's orders revealed an order for Morphine (Roxanol) 20 milligrams (mg) per milliliter, give 0.5 ml every 30 minutes as needed for pain or shortness of breath. Review of the medication administration record revealed the only dose administered to the resident was administered on 08/09/21 was at 6:00 A.M. Review of the Morphine Sulfate (Roxanol) 100 milligrams (mg) per five milliliter (ml) or 20 mg per ml solution concentration Controlled Drug Receipt/Record/Disposition Form for Resident #69 revealed on 08/09/21 at 6:00 A.M. 17 ml of Roxanol remained in the bottle. On 08/09/21 at 11:25 P.M. the Controlled Drug Receipt Record was corrected by LPN #300 and showed 14 ml of Roxanol remained. A set of unidentified initials were next to the corrected entry. Review of Licensed Practical Nurse (LPN) #300's employee file revealed a Performance Improvement Form (Form #412) dated 08/11/21 indicating poor work performance and the employee corrected a narcotic count without notifying management regarding a discrepancy. The form was signed by Registered Nurse (RN) #225 on 08/12/21 and was also signed by LPN #300. RN #225 issued the document to LPN #300. A Statement of Witness Form completed by LPN #350 dated 08/11/21 revealed during narcotic count on 08/09/21, the Morphine count was off (resident not identified on the statement) and LPN #300 corrected the Morphine count without notifying the on-call manager. On 10/27/21 at 4:04 P.M. interview with the Director of Nursing revealed the facility was unable to locate any investigation into the missing Roxanol for Resident #69 and indicated the facility would initiate an investigation at this time and submit a self-reported incident. The DON verified an investigation should have been initiated for misappropriation due to the facility being unable to account for the Roxanol and LPN #300 being written up for correcting the narcotic count/discrepancy without notifying the manager on call of the issue. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/27/21 at 4:58 P.M. interview with LPN #300 revealed she assumed responsibility of the medication cart knowing the Roxanol count was off from the previous shift and she did not notify management at that time. Further interview revealed the bottle should have had 17 ml in it during her count for the start of her shift but there was only 14 ml in the bottle. The LPN denied administering doses of Roxanol to Resident #69 during her shift on 08/09/21 but she corrected the narcotic sheet to reflect 14 ml and verified the entry on the sheet said corrected and her signature. The LPN stated the initials after her name were the initials of LPN #350. On 10/27/21 at 5:50 P.M. telephone interview with LPN #350 revealed she came on shift 08/09/21 and the Roxanol count for Resident #69 was incorrect. The LPN denied signing or placing her initials on the Roxanol record as she did not witness a waste of the Roxanol and was unaware of what happened to the missing Roxanol. LPN #350 stated she instructed LPN #300 to call the on-call manager per policy and notify the manager of the discrepancy but she stated LPN #300 corrected the entry without calling the manager so LPN #350 notified the on-call manager and completed the witness statement form. Review of the Controlled Substance Administration and Accountability Policy dated 01/01/21 revealed it was the policy of the facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility would have safeguards in place place in order to prevent loss, diversion or accidental exposure. Nursing staff must count all controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the director of nursing services or his or her designee immediately. Documentation should be made on the shift verification sheet. Review of the Abuse, Neglect and Exploitation Policy implemented 01/01/21 revealed was is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. An immediate investigation was warranted with suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur. This deficiency is an incidental finding to Complaint Number OH00126561.

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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 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32799 Based on record review, hospital record review, facility policy and procedure review and interview the facility failed to ensure appropriate equipment and physician orders were available to provide the necessary care and services for Resident #5, who required peritoneal dialysis. Actual harm occurred when Resident #5, who was admitted to the facility on [DATE] with hospital transfer orders for peritoneal dialysis (a type of dialysis that uses the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. It is used to remove excess fluid, correct electrolyte imbalances and remove toxins in those with kidney failure) was not provided the dialysis due to the facility not having the necessary equipment to provide it for the resident. This resulted in a significant change in condition requiring emergency transport to the hospital on [DATE] and an intensive care hospital stay for hyperbole (elevated potassium level), fluid overload, acute hypoxic respiratory failure and hypertensive crisis (elevated blood pressure) as a result of the resident not receiving peritoneal dialysis at the nursing home. The resident was hospitalized until [DATE]. This affected one resident (Resident #5) of three sampled residents. Findings include: Review of Resident #5's medical record revealed an admitted [DATE] with diagnoses including end stage renal disease, peritoneal dialysis, hypertensive kidney disease and muscle weakness. Review of Resident #5's hospital discharge orders, dated [DATE] revealed an order for peritoneal dialysis nightly. There were no additional specific orders related to the dialysis provided. Review of the physician's admission orders for Resident #5 revealed no order for peritoneal dialysis or clarification of the hospital transfer order for peritoneal dialysis. Further review of the medical record revealed an incomplete Nursing Admission Evaluation Part One Version 2 which contained the resident's vital signs: Temperature 97.1, pulse 86 per minute and regular, respirations 17 per minute and oxygen saturation 90% (normal greater than 92%) on room air. No assessment of the resident's skin, dialysis catheter, lungs or other systems were noted on the assessment. Further review of the medical record revealed no documentation of the resident's disposition upon arrival to the facility or the resident's arrival time. The first progress note was dated [DATE] at 8:00 P.M. and indicated the resident's wife called and wanted to know if the resident's dialysis had been started and the nurse explained the resident's dialysis would have to be run by gravity and the resident's wife stated that would be fine. Further review of the progress note revealed an entry dated [DATE] at 10:45 P.M. that indicated while reviewing Resident #5's orders it was noted there were no orders for dialysis, the discharging hospital was notified and they indicated they would fax the orders when they found them. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	An additional progress note, dated [DATE] at 1:47 A.M. revealed the discharging hospital could not find the resident's orders for dialysis and that it would have to wait until the nephrology (kidney specialists) team comes in the morning. There was no evidence the resident's physician was notified per review of the progress note. Review of an Admission Meeting Note, dated [DATE] at 2:20 P.M. revealed an admission meeting was held at this time in Resident #5's room. The resident reported he was not feeling well and voiced no concerns other than his health at that time. The note revealed the resident received dialysis at home. Review of the New Admission History and Physical, dated [DATE] and completed by Physician #375, revealed Resident #5 had a cardiac arrest and required cardiopulmonary resuscitation during his hospitalization prior to admission to the facility and seeing how they did CPR, I am sure he is having some shortness of breath. I figure out some of this could just be (due) to the possibility that he had some fractured ribs during that episode of CPR. The resident's biggest complaint was some shortness of breath. The plan was for the resident to follow up with cardiology given the cardiac arrest and the new onset of atrial fibrillation (irregular heartbeat) and the resident would need started on his dialysis. The note was dictated on [DATE] at 1:12 P.M. Review of the Situation, Background, Assessment and Recommendation (SBAR) Communication Form and Progress Note V3, dated [DATE] revealed Resident #5's vital signs at 12:09 P.M. were pulse 86 and regular, respirations 17, blood pressure ,d+[DATE] and oxygen saturation 90% on room air. The resident was lying in bed with slow, deep respirations with a rate of 13. The resident did not receive dialysis overnight and was short of breath and had labored breathing. The resident's overall condition was poor. The physician was notified on [DATE] at 3:00 P.M. and the resident was transported to the hospital. Review of the admitting hospital documentation, dated [DATE] revealed Resident #5, who had a history of end stage renal disease (ESRD) and on peritoneal dialysis (PD) presented with worsening of shortness of breath for two days after being unable to receive his PD at the facility. The resident was admitted to the intensive care unit (ICU) for hemodialysis to treat hyperkalemia and volume overload. The resident had acute hypoxic respiratory failure/volume overload due to inability to receive PD. The resident's betanaturetic peptide was 49,312 and a chest x-ray was suggestive of heart failure. Hemodialysis (HD) was ordered. The resident was currently on six liters of oxygen. The resident also had hyperkalemia due to his inability to receive PD. Nephrology ordered hemodialysis. The resident's blood pressure on presentation to the hospital was ,d+[DATE] (normal ,d+[DATE]). The resident was started on a nitroglycerine drip until HD could be started. Review of the Hospital Discharge Summary, dated [DATE] revealed Resident #5 presented to the hospital after worsening shortness of breath for two days after being unable to receive his PD. The resident had acute hypoxic respiratory failure in context of an exacerbation of congestive heart failure/volume overload due to the resident's inability to receive PD. The resident's condition improved after dialysis was resumed. The resident had acute diastolic and systolic CHF due to missed PD and was stabilized with dialysis. Hyperkalemia improved after hemodialysis and peritoneal dialysis resumed. The resident was able to discharge back to the facility per nephrology once it was ensured the facility would have all the peritoneal dialysis supplies and were able to continue PD. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:08 P.M. interview with Clinic Manager (CM) #425 revealed the facility contacted his company since Resident #5 received their services at home. CM #425 stated he made the facility aware they would not be able to provide the equipment needed for the resident's PD on the date he was admitted . Further interview revealed the facility should have the necessary PD equipment on hand for when they admit a resident who required PD. On [DATE] at 2:23 P.M. interview with Resident #5 revealed he was sent out to the hospital following his admission to the facility on [DATE] because he wasn't able to receive his peritoneal dialysis upon admission to the facility and he was admitted to the hospital due to extra fluid in my body from not getting dialysis The resident stated this caused him to be admitted to the hospital and receive hemodialysis. The resident stated the facility did not have the necessary equipment to provide his dialysis when he was admitted . On [DATE] at 3:57 P.M. interview with Physician #400 revealed he was one of the physicians caring for Resident #5 and his expectation would have been for the dialysis company/provider to have had the equipment at the facility for the facility to provide PD to the resident. On [DATE] at 4:10 P.M. interview with the Director of Nursing (DON) verified the medical record contained no evidence Resident #5 received his dialysis and the facility did not have the necessary equipment to provide PD to the resident when he was admitted to the facility. The DON also verified the hospital documentation from [DATE] indicated the resident was admitted to the hospital due to hypertensive crisis, acute hypoxic respiratory failure and hyperkalemia due to not receiving his PD. The DON revealed the dialysis company was to have the equipment to them prior to the resident's admission but this did not happen. Lastly, the DON verified the medical record did not contain documentation of the resident's condition on admission to the facility on [DATE]. On [DATE] at 4:11 P.M. interview with the Administrator revealed the facility did not re-admit Resident #5 until they were able to get the appropriate equipment to provide the resident's PD. On [DATE] at 4:22 P.M. interview with Registered Nurse (RN) #325 revealed the RN arrived to the facility around 8:00 P.M. on [DATE] and staff did not have the necessary equipment to provide Resident #5 with PD. Further interview revealed the nursing staff attempted to get the orders for dialysis but they had to wait until the following day. The facility received the orders from the hospital on [DATE] at 9:07 A.M. but then they were unable to get equipment for the resident from the original dialysis center and they reached out to a local dialysis provider that afternoon but the resident was sent to the hospital and admitted without receiving peritoneal dialysis at the facility. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:10 P.M. telephone interview with Licensed Practical Nurse (LPN) #450 revealed she was the nurse working the day Resident #5 had to be transferred to the hospital and admitted . The nurse stated she did not receive much information from the admitting nurse about the resident and was not informed he did not receive his dialysis throughout the night. LPN #450 stated the resident had no sign of receiving dialysis such as discarded supplies or any supplies in his room, she did not disconnect the resident from his dialysis the following morning and the resident reported to her he did not receive dialysis Further interview revealed the resident was admitted to the facility without a clarification of dialysis orders or necessary equipment to provide the dialysis. The LPN revealed the resident was initially short of breath but his condition continued to worsen and once the physician came in for rounds, she sent the physician back to the resident's room first for an evaluation and shortly after, the resident was sent out to the hospital and admitted with the listed diagnoses from the hospital. The LPN indicated it was crucial for dialysis residents to receive their treatments to prevent fluid overload. This deficiency substantiates Complaint Number OH00126561.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32799 Based on observation, record review and interview the facility failed to maintain a medication error rate of less than five (5) percent (%). The medication error rate was calculated to be 12% and included three medication errors of 25 medication administration observations. This affected two residents (#5 and #52) of six residents observed for medication administration. Findings include: 1. On 10/25/21 at 11:58 A.M. Licensed Practical Nurse (LPN) #200 was observed to obtain and prepare medications for Resident #5. The nurse prepared medications including Sevelamer carbonate (a phosphate binding medication used to treat elevated phosphate) 800 milligrams one tablet, Hydralazine (antihypertensive medication) 50 milligrams (mg) two tablets and Acidophilus (supplement) one capsule. At 12:03 P.M. LPN #200 was observed to enter the resident's room with the medications. The resident was observed lying in bed with the head of his bed elevated and his meal tray in front of him. The tray consisted of sausage and noodles, mashed potatoes, a roll and an empty dish with light yellow liquid. Interview with Resident #5 at the time of the observation revealed he had already eaten the pineapple that was in the dish. The LPN administered the resident's medications and exited the resident's room. At 12:05 P.M. interview with LPN #200 revealed the resident was administered the medications after he had eaten food from his meal tray and the time was 12:05 P.M. LPN #200 revealed lunch meal trays were served between 11:30 A.M. to 12:00 P.M. on the hall. Review of Resident #5's October 2021 Medication Administration record revealed the resident's Sevelamer carbonate medication was scheduled to be administered at 10:30 A.M. The medication was administered late. Review of Resident #5's physician orders revealed an order for Hydralazine 25 mg give two tablets four times a day and Sevelamer carbonate 800 mg before meals. On 10/25/21 at 4:38 P.M. interview with LPN #200 verified Resident #5 should have only received 50 mg Hydralazine and she administered 100 mg and verified the Sevelamer medication should have been administered before the resident's lunch meal per the physician's order. The LPN verified both medications were medication errors. 2. On 10/27/21 at 8:35 A.M. LPN #300 was observed to obtain and prepare medications for administration to Resident #52. LPN #300 prepared Tylenol 325 mg two tablets, Vitamin C 250 mg two tablets, Iron 65 mg, Benzotropine (for treatment of movement disorders), Metformin (for treatment of diabetes) 500 mg, Pepcid (reflux medication) 10 mg two tablets, Trazadone 50 mg one tablet and Klonopin (antianxiety medication) 0.5 mg one tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:40 A.M. LPN #300 was observed to administer the medications to Resident #52, crushed in pudding. Review of Resident #52's physician's orders revealed an order (dated 05/30/20) for Trazadone 50 mg give one half a tablet (25 mg) every day in the morning. On 10/27/21 at 12:00 P.M. interview with LPN #300 verified she administered Resident #52 the incorrect dose of Trazadone when she administered 50 mg instead of 25 mg as ordered. This deficiency substantiates Complaint Number OH00126561.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 32799 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure infection control practices were maintained during medication administration to prevent the spread of infection. This affected one resident (#22) of six residents observed for medication administration and had the potential to affect eight additional residents (#20, #26, #28, #29, #31, #33, #35 and #37) residing on C hall and who received blood glucose monitoring with the facility glucometer. The census was 111. Findings include: On 10/25/21 at 5:42 P.M. Registered Nurse (RN) #250 was observed during medication administration. At the time of the observation, RN #250 removed the glucometer from the medication cart, gatherer her additional supplies and entered Resident #22's room. At 5:43 P.M. RN #250 was observed to obtain a drop of blood from the resident's right index finger, placed it on the glucometer test strip and placed the glucometer directly on the table in the resident's room. Once the resident's blood sugar reading was completed. the RN gathered her supplies and exited the resident's room, placing the glucometer on top of the medication cart. RN #250 did not clean the glucometer before placing it back into the medication cart at at 5:50 P.M. On 10/25/21 at 5:50 P.M. interview with RN #250 verified she did not clean the glucometer prior to returning it to the drawer in the medication cart. RN #250 verified the glucometer should be properly cleaned after each resident use. The facility identified nine residents, Resident #20, #22, #26, #28, #29, #31, #33, #35 and #37 who resided on the C hall and who received blood glucose monitoring with the facility glucometer. Review of the Blood Glucose Machine Disinfection Policy, implemented 01/01/21 revealed the facility would ensure blood glucose machines were cleaned and disinfected after each use. During the observation, on 10/25/21 at 5:44 P.M. RN #250 asked Resident #22 about his pain. The resident complained of pain rated a seven on a 0-10 pain scale and indicated the pain was in his neck. RN #250 obtained one Percocet 10/325 tablet from the narcotic box in the medication cart. During the process, RN #250 was observed to pop the tablet from the narcotic card into her ungloved (bare) hand and then placed the Percocet into a medication cup. RN #250 then administered the medication to Resident #22. On 10/25/21 at 5:50 P.M. interview with RN #250 verified she should not handle medications with her bare hands as this contaminated the medication(s). Review of the Medication Administration Policy, implemented 01/01/21 revealed to remove medications from the source, taking care not to touch the medication with bare hands. On 10/27/21 at 2:53 P.M. during an interview with RN #700, the RN verified the glucometer should be disinfected after each use and medications should not be handled with bare hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency substantiates Complaint Number OH00126561.