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	03/07/2022

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 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** 07316 Based on closed medical record review, staff interview, and policy review, the facility failed to ensure a resident received appropriate treatment and care related to tracheostomy and ventilator care. This affected one of three residents reviewed for ventilator care (Resident #107). The facility census was 106. Findings include: Review of the closed medical record for Resident #107 revealed an admitted [DATE] and diagnoses including acute and chronic respiratory failure, morbid obesity, hypertension, seizures, pneumonia, tracheostomy, and ventilator dependent. Nurses notes indicated the resident was admitted on [DATE] around 12:50 P.M. The resident had a physician's order to be on oxygen per tracheostomy mask during the day and be on the ventilator at night only. The resident's vital signs and oxygen saturation were monitored on [DATE] at 1:00 P. M. 3:04 P.M. and 7:30 P.M. with no abnormalities noted. Review of the closed medical record for Resident #107 revealed no evidence of any respiratory assessments between [DATE] from 7:30 P.M. to [DATE] at 9:35 A.M. Review of a nurses note on [DATE] at 9:35 A.M. revealed at 7:30 A.M. the nurse had changed the resident from the ventilator to trach collar per orders. The resident was pleasant and responsive (no respiratory assessment or vital signs documented). At 9:00 A.M., the nurse entered the room and found the resident diaphoretic and pale. Attempted to check oxygen saturation level with no readable level. A code blue was called and CPR was started. 911 was called and the resident was transported to the hospital. The resident was currently still in the hospital as of [DATE]. Interview with LPN #150 on [DATE] at 10:50 A.M. revealed around 7:15 A.M., after coming on duty for the day shift, she switched Resident #107 from the ventilator to oxygen per tracheostomy. She stated he did well with that and his oxygen saturation levels were ,d+[DATE]% on the tracheostomy. She stated after that, the nursing assistant obtained vital signs which were within normal limits. She stated she then went in to his room and noted he was diaphoretic. She yelled for the unit manager, who came in immediately. They were unable to find a pulse and CPR was initiated. 911 was called and the resident was transferred to the hospital. She confirmed there was no documentation of any vital signs or respiratory assessments since the evening before. (continued on next page)

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

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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	Interview with Respiratory Therapist #154 on [DATE] on 11:25 A.M. revealed she was on duty when Resident #107 was admitted . She stated he was not on a ventilator (tracheostomy with oxygen only) upon admission and she completed a respiratory assessment on admission with no issues noted. She stated she then placed him on the ventilator on [DATE] at 7:30 P.M. She stated she completed another respiratory assessment with no distress noted. She stated she then left the facility between 8:,d+[DATE]:30 P.M. She stated residents with a tracheostomy or ventilator should have respiratory assessments completed every four hours to include breath sounds, pulse oxygen, respiratory rate, and pulse rate. She stated the assessment should include a check of the ventilator settings or oxygen rates for a tracheostomy. She stated respiratory assessments should be completed when switching a resident from just oxygen by tracheostomy to a ventilator or [NAME] versa. She confirmed there were no respiratory assessments or vital signs documented after 7:30 P.M. on [DATE]. Interview with Licensed Practical Nurse (LPN) #155 on [DATE] at 7:30 A.M. revealed she came on duty on [DATE] at 7:00 P.M. and was on duty until at least 7:30 A.M. on [DATE]. She confirmed Resident #107 was on a ventilator all night. She stated respiratory assessments and vital signs were conducted every four hours during the night but confirmed there was no documentation of this in the medical record. She confirmed she was in the room on [DATE] at around 7:00 A.M. when LPN #150 switched the resident from the ventilator to the oxygen by tracheostomy. She stated the resident was in no distress. She then left the facility after that. Review of the facility policy titled Ventilator Unit-General dated [DATE] revealed ventilator dependent residents shall have documentation completed each shift in the medical record. Respiratory status means: symmetry of chest wall expansion, respiratory rate and depth, sputum production, lung sounds, pulse oximetry values, vent settings, oxygen levels, signs or symptoms of hypoxia, airway patency (size of trach tube). Visual checks are done every two hours and documented. While the resident is on mechanical ventilation, assess and document the following every four to six hours: pulse rate, respiration rate, breath sounds, color and consistency of secretions, airway obstruction (suction as indicated), oxygen saturation, vital signs, and ventilator settings and alarms. There was no evidence respiratory assessments and vital signs were performed per policy for Resident #107. This deficiency substantiated Complaint Number OH00130093.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, staff interview, and policy review, the facility failed to ensure one resident (Resident #94) did not develop an avoidable pressure ulcer that declined from a Stage 2 (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) to Unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) , failed to ensure one resident, (Resident #41)who was admitted with pressure ulcers, did not develop an additional Unstageable pressure ulcer, and failed to ensure one resident (Resident #2) did not develop a Stage 3 (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer in the facility. This affected three of three residents reviewed for pressure ulcers (Residents #2, #41, and #94). The facility census was 106. This resulted in actual physical harm for Residents #41 and #94 who developed Unstageable pressure ulcers with necrosis on the heels in the facility. Findings include: 1. Review of the medical record for Resident #94 revealed an admitted [DATE] and diagnoses including traumatic brain injury, cerebral infarction with hemiplegia, and aphasia. A Braden skin risk assessment completed on 11/14/21 indicated the resident was at high risk for the development of pressure ulcers. A Minimum Data Set 3.0 (MDS) assessment completed 11/19/21 indicated the resident had long and short term memory problems, required extensive assistance from two staff with bed mobility, and had no pressure ulcers. Review of physician's orders revealed orders dated 08/17/20 to encourage/assist to float heels in bed as tolerated and encourage/assist to turn and reposition frequently. Review of nurse's notes dated 02/14/22 at 3:35 P.M. revealed Resident #94 was noted to have an area on the right heel that appeared to have been a blister that is now open to a Stage 2. The physician was notified and new treatment orders were obtained to cleanse right heel with wound cleanser and pat dry. Apply Collagen to wound bed, cover with a non-woven gauze, wrap with gauze, and secure with tape every shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Skin and Wound evaluation dated 02/14/22 revealed Resident #94 was noted to have a new in-house acquired Stage 2 (partial thickness skin loss with exposed dermis) pressure ulcer on the right heel measuring 2.7 centimeters (cm) long by 2.8 cm wide by 0.1 cm deep. Review of a Skin and Wound evaluation dated 02/24/22 revealed the resident's right heel was 2.2 cm long by 1.9 cm wide with depth marked not applicable. It stated the wound bed had 80 percent of the wound covered with epithelial tissue. (No necrosis was noted). It was noted to have bloody exudate. On 02/28/22 a Skin Assessment indicated the resident had an Unstageable area on the right heel (no measurements or description included). On 02/28/22 a physician's order was obtained for an air mattress for the bed due to poor mobility and poor skin integrity. Review of the plan of care, initiated 08/14/20, revealed the resident had pressure ulcer development on the right heel on 02/14/22. Interventions included encourage/assist to float heels when in bed as tolerated and remind/assist to turn/reposition frequently, more often as needed or requested. Observations on 02/28/22 at 9:30 A.M. revealed Resident #94 in bed on his right side with his heels touching the mattress. Observations of the right heel revealed a 2.8 cm long by 1.9 cm wide Unstageable area with black, necrotic skin on the outer heel. Licensed Practical Nurse (LPN) #150 stated, at that time, that the staff could not keep his heels elevated off the mattress with pillows. The Director of Nursing was in the room also and stated they could get some heel elevator boots for him. Observations on 02/28/22 at 2:45 P.M. revealed the resident in bed with his heels not elevated off the mattress (no heel elevation devices in place). Observations on 03/01/22 at 8:30 A.M., 10:30 A.M., and 12:36 P.M. revealed Resident #94 in bed on his right side with his heels resting on the mattress. The resident was not observed to have an air mattress on his bed. On 03/01/22 at 2:55 P.M. the resident was observed up in a wheelchair in the hallway. The resident was observed to have a hard soled tennis shoe on his right foot with his feet resting on the floor. Observations on 03/02/22 at 8:40 A.M. revealed the resident in bed on his right side with his heels resting on the mattress. No air mattress was observed on the bed. Interview with LPN #150, at that time, revealed the air mattress was ordered but had not come in yet. She stated she did not know if the facility had any heel elevator boots for the resident or not. Review of the treatment administration record for February 2022 revealed on 02/28/22 staff had documented that assistance to float heels in bed was provided with no refusals documented. Review of the treatment administration record for March 2022 revealed on 03/01/22 staff documented that assistance to float heels in bed and assistance to turn and reposition frequently was provided each shift. It was also documented that the resident had an air mattress on the bed every shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing on 03/02/22 at 9:15 A.M. revealed she did not realize the resident would not keep his heels elevated until he had a pressure ulcer on his heel. She stated they were in the process of getting him an air mattress for the bed and heel elevator boots, but they were not available yet. She further stated the resident should not be wearing hard soled tennis shoes on his right foot as it would put further pressure on the right heel. On 03/02/22 at 9:45 A.M. she confirmed the pressure ulcer on the heel developed in the facility on 02/14/22 and had not been measured since it had developed necrotic skin over the wound. She confirmed the skin assessment on 02/28/22 indicated an Unstageable area but did not include any measurements. On 03/03/22 at 9:00 A.M. she confirmed the pressure on the right heel was worse as it now had necrotic tissue over the wound. Review of the facility policy titled Pressure Injury Prevention and Management dated 01/01/21 revealed evidence based interventions for prevention would be implemented for all residents who are at risk or who have a pressure injury present. Interventions could include: redistribute pressure (such as repositioning, protecting and/or offloading heels); provide appropriate pressure redistributing support surfaces. Resident #94 developed an Unstageable pressure ulcer with necrotic tissue on the right heel without evidence physician ordered turning/repositioning and pressure relief to the heels was provided. 2. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including end stage renal disease, dementia, and adult failure to thrive. The resident went out for dialysis twice weekly. On 01/28/22 physician's orders were obtained to encourage to float heels as tolerated and encourage to turn and reposition as tolerated. On 01/28/22 a Braden skin risk assessment indicated the resident was at risk for the development of pressure ulcers. There was no evidence the resident's skin was assessed on admission for any skin breakdown. The first skin assessment was dated 02/03/22 (six days after admission). Interview with the Director of Nursing on 03/02/22 at 10:45 A.M. confirmed there was no assessment of Resident #41's skin until 02/03/22. She stated staff are to assess residents' skin on admission for any pressure ulcers/wounds. On 02/03/22 a Skin and Wound evaluation noted a deep tissue pressure injury (DTPI) (persistent non-blanchable deep red, maroon or purple discoloration, intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) on the right heel that was documented as being present on admission. The area measured 2.3 cm long by 3.4 cm wide with depth marked not applicable. It indicated the wound was covered with 100 percent epithelial tissue (tissue which manifests as light pink with a shiny pearl appearance). No necrosis (eschar) was noted. The resident was also noted with a Stage 2 pressure ulcer present on admission on the left ischial tuberosity measuring 0.6 cm long by 0.9 cm wide by 0.1 cm deep. The resident had a treatment ordered to cleanse the left ischial tuberosity with wound cleanser, pat dry, apply collagen, cover with foam dressing daily. On 02/05/22 a weekly skin assessment did not indicate any pressure areas on the right heel or left ischial tuberosity. An MDS assessment completed 02/07/22 indicated the resident required extensive assistance from two staff with bed mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/17/22 Skin and Wound evaluations noted the right heel to be a deep tissue injury pressure ulcer measuring 2.9 cm long by 3.9 cm wide with depth marked not applicable. It indicated the wound was covered with 100 percent epithelial tissue. No necrosis (eschar) was noted. The left ischial tuberosity was noted to be a Stage 2 pressure ulcer measuring 1.3 cm long by 1.3 cm wide. No depth documented. On 02/17/22 it was noted the resident had developed a new deep tissue pressure injury on the left heel measuring 2.6 cm long by 2.6 cm wide with depth marked not applicable. It indicated the wound was covered with 100 percent epithelial tissue. No necrosis (eschar) was noted. On 02/17/22 a physician's order was written for heel elevator boots to bilateral heels. On 02/23/22 an air mattress was ordered for the bed. Interview with the Director of Nursing on 03/02/22 at 10:45 A.M. confirmed the pressure ulcer on the left heel developed in the facility. On 02/24/22 Skin and Wound evaluations indicated the right heel was a deep tissue pressure ulcer measuring 1.6 cm long by 4.2 cm wide with depth not applicable. It indicated the wound was covered with 100 percent epithelial tissue. No necrosis (eschar) was noted. The left ischial tuberosity was noted to be a Stage 2 pressure ulcer measuring 1.0 cm long by 1.4 cm wide by 0.1 cm deep. The left heel was noted to be a deep tissue pressure injury (in house acquired) measuring 3.1 cm long by 2.6 cm wide with depth not applicable. It indicated the wound was covered with 100 percent epithelial tissue. No necrosis (eschar) was noted. Observations on 02/28/22 at 7:40 A.M. revealed Resident #41 to be in bed. The resident was observed with a 0.5 cm long by 2.5 cm wide by 0.1 cm deep open area on the left buttock covered with a piece of collagen. The skin around the wound was dark red/purple. There was no dressing over the collagen. Interview with the Director of Nursing, at that time, revealed she did not know why the resident did not have a dressing over the open pressure ulcer. Review of the treatment administration record revealed the dressing was documented as completed on the morning of 02/27/22. Interview with LPN #151 on 02/28/22 at 8:00 A.M. (the nurse providing care for Resident #41) revealed she was not aware the resident did not have a dressing on the pressure ulcer on the left buttock (documented as ischial tuberosity). Observations on 03/01/22 at 8:25 A.M., 10:25 A.M. and 12:35 P.M. revealed Resident #41 in bed with her heels resting on the mattress. The resident did not have any heel elevator boots on. Observations on 03/02/22 at 10:00 A.M. of Resident #41's heels revealed the left heel to have a 4.1 cm long by 3.1 cm wide Unstageable pressure ulcer covered with brown eschar. The right heel had a 2.5 cm long by 4 cm wide Unstageable pressure ulcer covered with dark brown/black eschar. Review of the treatment administration record for March 2022 revealed that on 03/01/22 the heel elevator boots were documented to indicate they were worn by the resident for the day shift. It was also documented that the heels were floated. The treatment administration record also monitored a target behavior of refusing care but documented this did not occur on 03/01/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing on 03/02/22 at 10:00 A.M. and 10:45 A.M. revealed Resident #41 was to have heel elevator boots on when in bed. She also confirmed there was no documentation to indicate the resident refused care on 03/01/22. She confirmed the skin and wound evaluations did not indicate the resident had any eschar on the heels. She stated the resident had eschar on her heels prior to 03/02/22 but the skin and wound evaluations were inaccurate. She confirmed the resident could not have 100 percent epithelial skin over the wounds when eschar was present. Resident #41 developed an Unstageable pressure ulcer with necrotic tissue to the left heel in the facility and had worsening of an Unstageable pressure ulcer on the right heel without evidence that physician ordered pressure relief was provided. 3. Review of the medical record for Resident #2 revealed a readmitted [DATE] with diagnoses including acute and chronic respiratory failure, chronic obstructive pulmonary disease, and malnutrition. A Braden pressure ulcer risk assessment completed on 12/20/21 indicated the resident was high risk for the development of pressure ulcers. The admission skin assessment documented the resident did not have any pressure ulcers. The resident was receiving hospice services. A MDS assessment completed 01/21/22 indicated the resident had a brief interview for mental status score of 2, indicating severe cognitive impairment. The resident required extensive assistance from two staff for bed mobility and had no pressure ulcers. A weekly skin assessment on 01/10/22 stated the resident had no existing or new skin areas. A nurses note on 01/16/22 at 8:03 A.M. documented a new order was obtained for wound care for the midspine. There was no description or measurements of the area. There was no evidence a physician's order was implemented for a treatment to the midspine at that time. A weekly skin assessment on 01/18/22 stated the resident had no existing or new skin areas. A nurses note on 01/19/22 at 3:36 P.M. documented a new order was obtained to cleanse area on spine and apply hydrocortisone ointment and cover with dressing three times per week. However, review of the treatment administration record for January 2022 revealed a treatment to the spine was first documented on 01/21/22. (5 days after it was identified). A weekly skin assessment on 02/03/22 documented the resident had no existing or new skin areas. A skin and wound evaluation on 02/10/22 stated the resident had a Stage 3 (full-thickness skin loss) pressure ulcer, in house acquired, on the spine measuring 0.2 cm long by 0.4 cm wide by <0.1 cm deep. It indicated the wound was filled with 100 percent slough. This was the first time the wound was measured or described since noted in the nurses notes on 01/16/22. Interview with the Director of Nursing on 03/02/22 at 9:00 A.M. confirmed the pressure ulcer assessments were inaccurate and the area was not measured until 02/10/22 (after being identified on 01/16/22). She confirmed pressure ulcers are to be monitored weekly. She stated hospice had documentation on the pressure ulcer but that the facility did not have those records. She confirmed there was no evidence a physician's order was obtained for a treatment to the area until 01/19/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A weekly skin assessment on 02/17/22 documented the resident had no existing or new skin areas. However, a Skin and Wound evaluation on 02/17/22 stated the resident had a Stage 3 pressure ulcer on the spine measuring 0.5 cm long by 0.5 cm wide, with depth as not applicable. It was noted to be improving. A weekly skin assessment on 02/24/22 stated the resident had an area on the spine appearing as a Stage 1. A Skin and Wound evaluation on 02/24/22 stated the area measured 1.0 cm long by 1.0 cm wide with depth not applicable. Review of physician's orders revealed an order 01/19/22 to reposition the resident every two hours as tolerated. Review of the plan of care, initiated 10/26/21, revealed an intervention stating the resident needed reminding/assistance to turn/reposition every two hours, more often as needed or requested. Observations on 02/28/22 at 2:30 P.M. revealed Resident #2 to have a 1.0 cm in diameter moist wound with a white center on the mid back. The skin around the wound was reddened. The wound was near a protrusion of the spine. Observations on 03/01/22 at 8:15 A.M., 10:32 A.M. and 12:30 P.M. revealed Resident #2 to be in bed in the same position with a pillow under her left side, tilting the resident slightly to the right. The resident was observed to have a regular pressure reducing mattress on the bed. Review of the treatment administration record for 03/01/22 revealed it was documented the resident was repositioned every two hours at 8:00 A.M., 10:00 A.M., and 12:00 P.M. There was no evidence of any refusals to turn/reposition. Interview with Medication Technician #152 (who signed off the treatment administration record for turning on 03/01/22 at 8:00 A.M., 10:00 A.M. and 12:00 P.M.) on 03/01/22 at 3:45 P.M. revealed the resident should be repositioned rotating from the back to left side to right side every two hours. She stated she did not verify the position every two hours but went on what the nursing assistants told her. She confirmed she documented the resident was repositioned every two hours. Interview with State tested Nursing Assistant (STNA) #153 on 03/01/22 at 3:50 P.M. (STNA providing care for Resident #2) revealed they shove a pillow under the resident but do what the resident wants. She stated the resident will pull the pillow out and return to laying on her back. (Although the resident was observed in the same position with the pillow under her left side from 8:15 A.M. to 12:30 P.M.). Review of the facility policy titled Pressure Injury Prevention and Management dated 01/01/21 revealed licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Interview with the Director of Nursing on 03/02/22 at 9:00 A.M. revealed the facility was in the process of obtaining an air mattress for the resident's bed. She stated when the Stage 3 was identified, the resident should have had an air mattress added to the bed. This deficiency substantiated Master Complaint Number OH00130269.