Printed: 02/22/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022	
NAME OF PROVIDER OR SUPPLIER  Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street Marietta, OH 45750	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)	
F 0558  Level of Harm - Minimal harm or potential for actual harm	Reasonably accommodate the needs and preferences of each resident.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440			
Residents Affected - Few	Based on observation, record review, facility policy and procedure review and interview the facility failed to adequately accommodate Resident #6's ability to call for assistance by providing a call signal device the resident could activate. This affected one resident (#6) of six residents reviewed for physical environment. Findings include:  Review of Resident #6's medical record revealed the resident was admitted to the facility on [DATE] with			
	diagnoses including diffuse traumatic brain injury without loss of consciousness, chronic respiratory failure, quadriplegia, cognitive communication deficit, and essential hypertension.  Review of Resident #6's care plan, dated 10/13/22 revealed no focus regarding the resident not being able use call system or related to the resident's needs in summoning staff assistance.  Review of Resident #6's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/20/22 revealed the resident was severely cognitively impaired and required total dependence from two plus people to assist wibed mobility, transfers, dressing, toileting and personal hygiene.  Review of the current physician's orders for Resident #6 revealed no order for frequent checks/increased monitoring due to the resident not being able to use a call light.  On 10/31/22 at 3:56 P.M. observation revealed Resident #6 had been provided a thumb press call device. An interview at the time of the observation with Resident #6's family member revealed Resident #6 could n activate the call device. Resident #6's family member reported in the past, Resident #6 had a flat call device but she was having trouble activating it. Resident #6's family member reported the facility had not provided call signal device Resident #6 could easily use to call for assistance.  On 11/02/22 at 9:17 A.M. interview with Respiratory Therapist (RT) #23 revealed he had seen different call			
	devices for residents with brain inju	uries. Two examples of call devices for esident would hit with their hand and or	residents with brain injuries he	

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 365687

If continuation sheet Page 1 of 30

No. 0938-0391			NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street Marietta, OH 45750	P CODE
For information on the nursing home's p	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying informati	on)
F 0558  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	have a call signal device she could call device would work or be most at On 11/02/22 at 9:21 A.M. interview couple of fingers on her right hand On 11/02/22 at 9:41 A.M. LPN #94 activated by tapping it. Resident #6 her to.  On 11/02/22 at 9:43 A.M. interview record to check her more frequently plan regarding checks more freque with no call device to activate, Resi assistance.  Review of the facility policy titled Carevealed each resident would be exaccommodations that might be nee accommodations would be identified.	with Licensed Practical Nurse (LPN) # use and there had not been an assess appropriate for the resident to summon with Registered Nurse (RN) #56 reveal and move her head.  was observed to provide Resident #6 was observed to be able to activate the with RN #56 verified there were no order than every two hours with turning and the every two hou	ment completed to evaluate what assistance from staff.  Iled Resident #6 could move a  with a flat call device that was the call device when LPN #94 asked the call device when LPN #94 asked the call device when LPN #95 asked the call device when LPN #96 verified the care and repositioning. RN #56 verified the care are call system. Special the call system. Special an of care and provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X3) PROVIDER ON NUMBER: 365687  (X2) MULTIPLE CONSTRUCTION A. Building B. Wing  (X3) DATE SURVEY COMPLETED 11/15/2022  NAME OF PROVIDER OR SUPPLIER Arbors at Marietta  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each 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)  Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limiter receiving treatment and supports for daily living safety.  ***NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801  Based on observation, record review, review of a facility concern log and interview the facility failed to ensure resident (82) of three resident #22 property and failed to ensure national receiving residents (827, #80), and #21 whose rooms were observed ultimg the initial review municipated in roy repair. This affected one resident (82) of three residents reviewed for missing personal property, three residents (827, #80), and #21 whose rooms were observed ultimg the initial review municipated in roy residents (827, #80, and #21 whose rooms were observed ultimg the initial resident pool and had the potential to affect 19 additional residents (#3, #5, #10, #23, #27, #32, #33, #47, #59, #80, #87, #71, #74, #91, #93, #98, #101, #106, and #260) identified by the facility to need a new over bed table.  Findings include:  1. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including he disease, type two diabetes, chronic obstructive pulmonary disease, resides leg syndrome, anxiety, and allergic chrinitis.  Review of a facility concern log, dated 11/10/21 to 10/18/22 revealed no evidence Resident #2's name was listed on the concern log or evidence of any concerns with missing items.  On 10/31/22 at 1.49 P.M. Interview with Nesident #2' revealed she had				NO. 0936-0391
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)  Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited receiving treatment and supports for daily living safely.  "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 32801  Based on observation, record review, review of a facility concern log and interview the facility failed to exercise reasonable care for the protection of Resident #2's property and failed to ensure missing property was replaced timely. The facility also failed to ensure resident furture and walls were in maintained in go repair. This affected one resident (#2') of there residents reviewed for missing personal property, three residents (#27, #80, and #72) whose rooms were observed during the initial resident pool and had the potential to affect 19 additional residents (#3, #5, #10, #23, #27, #32, #39, #47, #59, #60, #67, #71, #74, #31, #33, #38, #101, #106, and #250) identified by the facility on [DATE] with diagnoses including her disease, type two diabetes, chronic obstructive pulmonary disease, resitess leg syndrome, anxiety, and allergic rhinitis.  Review of Resident #2's census data revealed the resident resided on the E unit from 11/24/21 to 12/08/2  Review of a facility concern log, dated 11/10/21 to 10/18/22 revealed no evidence Resident #2's name was listed on the concern log or evidence of any concerns with missing items.  On 10/31/22 at 1:49 P.M. interview with Resident #2 revealed she had a red duffel bag that was missing it contained two books. Depends, tapes, jewelry and a death book. The resident stated she had to move to I hall for two weeks (in 2021) due to COVID and when she returned to her original come her duffel bag and belong		IDENTIFICATION NUMBER:	A. Building	COMPLETED
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited receiving treatment and supports for daily living safety.  "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 32801  Based on observation, record review, review of a facility concern log and interview the facility failed to exercise reasonable care for the protection of Resident #2's property and failed to ensure missing property, was replaced timely. The facility also failed to ensure resident furniture and walls were in maintained in go repair. This affected one resident (#2) of three residents reviewed for missing personal property, three residents #2's property and failed to ensure missing property, was replaced timely. The facility also failed to ensure residents from the potential to affect 19 additional residents (#3, #10, #2, #3, #4, #3, #3, #4, #5, #60, #67, #71, #74, #91, #93, #89, #101, #106, and #250) identified by the facility to need a new over bed table.  Findings include:  1. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including her disease, type two diabetes, chronic obstructive pulmonary disease, restless leg syndrome, anxiety, and allergic rhinitis.  Review of Resident #2's census data revealed the resident resided on the E unit from 11/24/21 to 12/08/2*  Review of a facility concern log, dated 11/10/21 to 10/18/22 revealed no evidence Resident #2's name war listed on the concern log or evidence of any concerns with missing items.  On 10/31/22 at 1:49 P.M. interview with Resident #2 revealed she had a red duffel bag that was missing the contained two books, Depends, tapes, jewelry and a death book. The resident stated she had to move to fall for two weeks (in 2021) due to COVID and when she returned to her original room her duffel bag and belongings were missing. The resident stated sh			400 Seventh Street	P CODE
(Each deficiency must be preceded by full regulatory or LSC identifying information)  F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801  Based on observation, record review, review of a facility concern log and interview the facility failed to exercise reasonable care for the protection of Resident #2's property and failed to ensure missing property was replaced timely. The facility also failed to ensure resident furniture and walls were in maintained in go repair. This affected one resident (#2) of three residents reviewed for missing personal property, three residents (#27, #60, and #72) whose rooms were observed during the initial resident pool and had the potential to affect 19 additional residents (#3, #5, #10, #23, #27, #32, #39, #47, #59, #60, #67, #71, #74, #91, #93, #98, #101, #106, and #260) identified by the facility to need a new over bed table.  Findings include:  1. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including her disease, type two diabetes, chronic obstructive pulmonary disease, resitess leg syndrome, anxiety, and allergic rhinitis.  Review of Resident #2's census data revealed the resident resided on the E unit from 11/24/21 to 12/08/2 Review of a facility concern log, dated 11/10/21 to 10/18/22 revealed on evidence Resident #2's name ware listed on the concern log or evidence of any concerns with missing items.  On 10/31/22 at 1:49 P.M. interview with Resident #2 revealed she had a red duffel bag that was missing the contained two books, Depends, tapes, jewelry and a death book. The resident stated she had to move to I hall for two weeks (in 2021) due to COVID and when she returned to her original room her duffel bag and belongings were missing. The resident stated she had reported the missing items to the previous Administrator, and the previous Administrator reported he would replace the bag; however, he never did.  On	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
receiving treatment and supports for daily living safely.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801  Based on observation, record review, review of a facility concern log and interview the facility failed to exercise reasonable care for the protection of Resident #2's property and failed to ensure missing property was replaced timely. The facility also failed to ensure resident furniture and walls were in maintained in go porepair. This affected one resident #2'D free residents reviewed for missing personal property, three residents (#27, #60, and #72) whose rooms were observed during the initial resident good and had the potential to affect 19 additional residents (#3, #5, #10, #23, #27, #32, #39, #47, #59, #60, #67, #71, #74, #91, #93, #98, #101, #106, and #260) identified by the facility to need a new over bed table.  Findings include:  1. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including hed disease, type two diabetes, chronic obstructive pulmonary disease, restless leg syndrome, anxiety, and allergic rhinitis.  Review of Resident #2's census data revealed the resident resided on the E unit from 11/24/21 to 12/08/2.  Review of a facility concern log, dated 11/10/21 to 10/18/22 revealed no evidence Resident #2's name was listed on the concern log or evidence of any concerns with missing items.  On 10/31/22 at 1.49 P.M. interview with Resident #2 revealed she had a red duffel bag that was missing it for two weeks (in 2021) due to COVID and when she returned to her original room her duffel bag and belongings were missing. The resident stated she had reported the missing items to the previous Administrator, and the previous Administrator reported he would replace the bag; however, he never did.  On 11/01/22 at 5:28 P.M. interview with the Director of Nursing (DON) revealed she remembered Resident #2 reporting the missing red bag; however, she thought have written anything on paper. The DON revealed the previous Administrator l	(X4) ID PREFIX TAG			
paperwork regarding Resident #2's red bag that was reported to the pervious Administrator as missing. The Administrator reported he just went and spoke to the resident, and stated the resident told him she was no worried about replacing the contents of the bag, however, she would like the red bag replaced. The Administrator revealed he showed the resident some red bags on Amazon, and she agreed on one, the facility would order it and it would be here in a few days.  45440  (continued on next page)	Level of Harm - Minimal harm or potential for actual harm	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  Honor the resident's right to a safe, clean, comfortable and homelike environment, including but no receiving treatment and supports for daily living safely.  **NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3280  Based on observation, record review, review of a facility concern log and interview the facility failed exercise reasonable care for the protection of Resident #2's property and failed to ensure missing i was replaced timely. The facility also failed to ensure resident furniture and walls were in maintaine repair. This affected one resident (#2) of three residents reviewed for missing personal property, the residents (#27, #60, and #72) whose rooms were observed during the initial resident pool and had potential to affect 19 additional residents (#3, #5, #10, #23, #27, #32, #39, #47, #59, #60, #67, #71 #91, #93, #98, #101, #106, and #260) identified by the facility to need a new over bed table.  Findings include:  1. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses includisease, type two diabetes, chronic obstructive pulmonary disease, restless leg syndrome, anxiety, allergic rhinitis.  Review of Resident #2's census data revealed the resident resided on the E unit from 11/24/21 to 18 Review of a facility concern log, dated 11/10/21 to 10/18/22 revealed no evidence Resident #2's no listed on the concern log or evidence of any concerns with missing items.  On 10/31/22 at 1:49 P.M. interview with Resident #2 revealed she had a red duffel bag that was micontained two books, Depends, tapes, jewelry and a death book. The resident stated she had to mail for two weeks (in 2021) due to COVID and when she returned to her original room her duffel be belongings were missing. The resident stated she had reprevious Administrator, and the previous Administrator reported he would replace the bag; however, he new On 11/10/122 at 5:28 P.M.		conment, including but not limited to constitute the facility failed to failed to ensure missing property of walls were in maintained in good sing personal property, three ial resident pool and had the , #47, #59. #60, #67, #71, #74, ew over bed table.  TE] with diagnoses including heart as leg syndrome, anxiety, and  E unit from 11/24/21 to 12/08/21.  Evidence Resident #2's name was led duffel bag that was missing that ident stated she had to move to E foriginal room her duffel bag and no items to the previous he bag; however, he never did.  Everalled she remembered Resident inistered had addressed the issue. Oncern log and stated she would ext. The DON revealed the previous or revealed he could not find any ous Administrator as missing. The the resident told him she was not the red bag replaced. The

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NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street Marietta, OH 45750	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact 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)			ion)
F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	resident's bed and to the left of the On 11/02/22 at 8:46 A.M. observati not in good repair and needed pain b. On 10/31/22 at 10:58 A.M. observati patched area in need of being pain On 11/02/22 at 8:50 A.M. observati needed painted. c. On 10/31/22 at 3:11 P.M. observ edges. Interview with Resident #60 while. Resident #60 reported it was On 11/02/22 at 8:48 A.M. observati needed a new over bed table. Review of an over bed table audit of #27, #32, #39, #47, #59. #60, #67, which were in disrepair and needed Review of the facility policy titled Sa accordance with residents' rights, ti	rvation of Resident #27's wall behind heted.  Ion of the area with MD #116 verified the ration of Resident #60's over bed table that the time of the observation revealed rough on her arms and sometimes shown with MD #116 verified the table was completed by the facility revealed 19 re #71, #74, #91, #93, #98, #101, #106, a	as in need of being painted.  tor (MD) #116 verified the wall was er bed revealed a large white  ne wall was not in good repair and revealed the table had rough d the table had been like that for a e would scratch herself on the table. s in disrepair and Resident #60 esidents, Resident #3, #5, #10, #23, and #260 had over bed tables red/revised 01/01/22 revealed in comfortable, and homelike

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Arbors at Marietta		400 Seventh Street Marietta, OH 45750			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0602	Protect each resident from the wro	ngful use of the resident's belongings of	or money.		
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	NAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 28923		
Residents Affected - Few	Based on record review, review of facility Self-Reported Incidents (SRIs) and related investigation, review of controlled drug records/disposition forms, review of an employee personnel file, facility policy and procedure review and staff interview the facility failed to ensure residents were free from misappropriation of controlled (narcotic) medications. This affected two residents (#86 and #110) of three residents reviewed for misappropriation of medication.				
	Findings include:				
	1. A review of Resident #86's closed medical record revealed the resident was originally admitted to the facility on [DATE] with a readmitted [DATE]. The resident had diagnoses including a left femoral neck fracture (hip fracture), low back pain, and the presence of bilateral artificial hip joints. Record review revealed the resident was discharged home on 10/24/22.				
	A review of Resident #86's admission Minimum Data Set 3.0 (MDS) assessment, dated 07/14/22 revealed the resident did not have any communication issues as he was able to make himself understood and was able to understand others. The assessment revealed the resident was cognitively intact and was not known to display any behaviors. A pain assessment revealed the resident did report having pain in the last five days and the pain was almost constantly. He rated the pain a 10 on a 1-10 scale at the worst during the last five days. The MDS assessment noted the pain did not affect his sleep at night but did limit his day-to-day activities.				
	A review of Resident #86's care plans revealed a plan of care, initiated 10/01/22 related to the resident's risk for pain related to a left hip fracture, osteoarthritis, low back pain, and spinal stenosis. The goal was for the resident to have adequate pain control and for him to verbalize adequate relief of pain or the ability to cope with incompletely relieved pain. The interventions included administering his pain medications as ordered.				
	A review of Resident #86's physician's orders revealed the resident had an order in place to receive Pero (a controlled narcotic pain medication used in the treatment of moderate to severe pain) 5- 325 milligram (mg) with directions to give one tablet by mouth every six hours as needed (PRN) for pain rated a three to on a 1-10 scale. The instructions indicated two tablets could be given for pain levels between a seven an on a 1-10 scale.				
	(continued on next page)				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	documented administering the resi of 10/11/22 into the morning of 10/10/13/22. During all four administratwo of the 5-325 mg tablets with earning been given to the resident of physician on when to administer the on a 1-10 scale at the time of the abe given unless the resident's pain the PRN Percocet when his pain let the physician's orders again on 10/1 mg tablets for a pain level of a 6 or Disposition form indicated RN #126 A review of facility self-reported incomisappropriation of resident proper Resident #86, who was identified to provide meaningful information who of diarrhea. The alleged/ suspected administrator was made aware Rehis prescribed pain medication by the side, so the oncoming day shift Resident #86 called for Licensed Pills that had been given to him that Upon further investigation, it was conclused the resident #86's pleased the investigation. Resident #86's pleased the investigation. Resident #86's pleased the investigation. The local pocontrolled narcotic pain medication conclusion of their investigation inconclusion of their investigation inconclusion.	tion administration record (MAR) for Oxident his PRN Percocet twice during he 12/22 and again the evening of 10/12/2 ations of the PRN Percocet, RN #125 dich dose given. The two tablets of Percord 10/11/22 at 10:20 P.M. did not follow the PRN Percocet. The resident's pain led diministration. The physician's orders of level was a 3 or higher. The resident was a 3 or higher. The resident was a 1-10 scale. Documentation on the Note administered a total of four Percocet of a 1-10 scale. Documentation on the Note administered a total of four Percocet of the two was made on 10/13/22. The initial state of the tresident victim. Resident #86 of the resident victim. Resident #86 of the resident was a staff member not in the note of the perpetrator was a staff member not in the note of the perpetrator was a staff member not in the note of the perpetrator was a staff member not in the note of	r night shift going from the evening 2 going into the morning of ocumented she gave the resident ocet that were documented as a the parameters set forth by the vel was recorded as only being a 2 id not permit the PRN Percocet to was only to receive two tablets of ollow the parameters specified with ted she gave two Percocet 5- 325 MAR and Controlled Drug Record/ablets the night of 10/13/22.  Evealed an allegation of ource of the allegation was from was noted to have been able to ant had on the resident was reports tentified in the initial report.  Docation of the occurrence was on the incident revealed the facility on the wrong medication in place of ot take the medication and sat it to the en. Shortly after 7:00 A.M., his room. He showed the nurse the tercocet) medication.  In which was brought to the suspended pending the outcome of the facility's investigation, and it to lace 100 mg capsules on a and LPN #112 as part of the he alleged misappropriation at the although misappropriation was

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F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	resident reported in his statement to for pain and he did not get any relia informed another nurse about it (LF were given to him and told him what the same pain pills he was familiar 10/13/22, the resident indicated he right. The nurse took them back, lo come from a new box. He had to prout of his mouth.  A witness statement from LPN #11 did not know what the night shift nu #86 informed LPN #112 he was in to her that he was using the bathro the resident declined. The resident #112 stated she told the resident to numbers on them as his PRN Perce things up and prove he was getting the pills he was given the next nigh morning of 10/13/22. The nurse ind stool softeners. At that time, the resident with the resident from the evening of 10/12/give him his pain medication. She agone to the bathroom, so she gave A review of RN #125's employee findicated the RN had a hire date of company policy related to medication unterview on 10/20/22. December 10/20/22.	to the facility's Administrator, sent 10/22 to the morning of 10/13/22, she wold also gave the resident stool softeners at him two stool softeners after his pain relie revealed a Performance Improveme 702/28/20. The reason for counseling/ons given without a physician's order, wo comentation was also not taking place mproper wasting of a narcotic pain medical pain medical stoods.	e nurse (RN #125) gave him pills did they make him sleep. He heck his pills the next time they ad received four pills that were not 2 going into the morning of she was giving him did not look o him while telling him they had until she left and then he took them to her the morning of 10/12/22 he it was not his pain pills. Resident could not sleep. He also reported in him to file a complaint then, but the proper pain medication. LPN bey did not have the identifying the nurse hoped that would clear wever, it did not. The resident kept on and showed LPN #112 the nat was given to the resident were 20/22 at 10:36 A.M. revealed, on the Resident #86 that morning to she had told her earlier he had not medication.  Int Form dated 10/20/22. The form corrective action was for violating which was verified by RN #125 at the time medication was being

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	10/27/22 that revealed the facility's about RN #125. A description of the misappropriation. Their investigation termination from employment. The indicated to have had pain manage indicated to have received the wrong was signed off as having been admidespite him having unrelieved pain administered a medication (Colace reported he was given the wrong material revealed the nurse gave Colace to signing the medication administration medication.  A review of a Controlled Drug Receincluded in the facility's investigation Percocet twice on the evening of 10/12/22 going into the morning ho	included a complaint form to the State of Director of Nursing (DON) filed a comple complaint or violation revealed RN # on revealed violations of three company involved resident was mentioned in the ement issues related to the practice breng medication and reported he did not ininistered to him. The DON indicated in that kept him up all night. The involved without a physician's order to do so. The dication when he asked for his PRN in the resident without an order, inappropon record (MAR's) at the correct times, sipt/ Record/ Disposition form for Resident file revealed RN #125 documented so D/11/22 going into the morning hours of urs of 10/13/22. Both times she signed at Acetaminophen) 5-325 milligrams (market in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete in the complete in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete in the signed at Acetaminophen) 5-325 milligrams (market in the complete	plaint with the Board of Nursing 125 had been suspended for policies that resulted in here complaint and the resident was receive the pain medication that to harm occurred to the resident dinurse was also indicated to have the DON added the resident pain medication. Their investigation priate documentation related to and improper waste of a narcotic tent #86's Percocet that was the gave the resident his PRN for 10/12/22 and again the evening of the reflect she gave the resident
	about three weeks ago. The reside reported to administration) he did no requested and the resident suspect showed the resident what his PRN correct medication. The next morning resident had four stool softeners to requested his Percocet pain medication. The next morning resident had four stool softeners to requested his Percocet pain medication. The next morning resident had four stool softeners to requested his Percocet. She denied the before (10/11/22- 10/12/22), the resident had four stools are resident.	with LPN #112 revealed the incident in told her the morning of 10/12/22 (the tot get his pain medication from the nig ted the nurse gave him something else Percocet looked like after he questioning (10/13/22) when she came to work, show her that he stated had been give ation. LPN #112 verified what the resident had an order to receive Colac sident reported he was up all night with the PRN Percocet was ordered on a Priministered. The LPN revealed the resident.	e day before the incident was ht shift nurse (RN #125) as he instead. The LPN stated she ed whether he was being given the the resident asked to see her. The nto him by RN #125 after he had lent was given was Colace and no e. The LPN revealed the night pain and had to go to the RN basis and the resident would

(continued on next page)

were not the same that he had received previously.

capsules each time he asked for his PRN Percocet. The second time the resident was supposedly given his PRN Percocet (the morning of 10/13/22), LPN #112 revealed the resident got two more Colace in place of his PRN Percocet when he did not even ask for it. The resident was reportedly told (by RN #125) they looked different because they came out of a different box when the resident questioned why they looked different from his usual PRN pain medication. The resident recognized the PRN Percocet given to him by RN #125

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	misappropriation of Resident #86's medications. LPN #112 was the first not have immediate concerns where aware LPN #112 showed the reside was wrong, he would know. On the requested pain mediation and RN # medication to the side after not take medication and he informed her the telling him they came in a new box. after she left the room. LPN #112 ctle LPN #112 the medication that was the PRN pain medication was not he capsules of Colace were shown to reported the incident to the Administracility suspended RN #125 pendin #125 took the PRN Percocet, they facility investigation the they looked with PRN pain medications. The Adhis PRN pain medications here and administer it to the resident more for ordered on a PRN basis was given narcotic pain medications during the of their investigation into Resident inconclusive. They suspected RN # policy on medication diversion did without evidence of the employee's investigation hit a dead end as well #86 was reimbursed for the PRN Packnowledged the four doses could was given to the resident for those given. The DON confirmed there we basis. She stated that was what the without an order. The DON acknow provided parameters in which the FAR A review of the facility policy on Ab of the facility to provide protections implementing written policies and painsappropriation of resident proper deliberate misplacement, exploitation.	stigation of SRI tracking number 22801 PRN Percocet. Resident #86 thought to the percocet. Resident #86 thought to the anabout the resident's concerns in it was first brought to her attention. The ent what his Percocet looked like so in the evening of 10/12/22 going into 10/13/2 #125 brought medication into him that of the first hem. Later that morning, RN #125 by did not look right. RN #125 looked at the resident placed the medication until the resident placed the medication until the process of	things did not seem right with his to (on 10/11/22), but stated she did he Administrator and DON were the event he thought something 22, the resident reported he didn't look right. He placed the came in again with his PRN pain to them then gave them back to him had the day shift nurse. He showed ain medication. LPN #112 verified the Administrator confirmed four as second night that LPN #112 hed and a SRI was initiated. The evealed although the suspected RN ministrator revealed as part of the ation to see if a pattern was seen him Resident #86 may have used 125 worked she seemed to of Resident #86's pain medication is with other residents controlled the Administrator indicated, because substantiated as their evidence was not feel they could prove it. Their cited of medication diversion ince. He believed the local police sygraph test. He denied Resident to a scheduled or PRN see, since she administered it sician's orders regarding the todose.  101/01/22 revealed it was the policy arch resident by developing and use, neglect, exploitation, and for resident property meant the ent use of a resident's belongings or

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

property.

(continued on next page)

Facility ID: 365687

money without the resident's consent. Possible indicators of abuse included resident reports of theft of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	:IENCIES full regulatory or LSC identifying informati	on)
F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	[DATE] with diagnoses including the replacement surgery.  A review of Resident #110's Minimal did not have any communication is understand others. The assessment not known to have displayed any be that she rated a 7 on a 1-10 scale aday to day activities.  A review of Resident #110's care perelated to a recent left knee replace the ability to cope with incompletely ordered.  A review of Resident #110's physical Acetaminophen (Norco) 5- 325 mg 6-10 on a 1-10 scale.  A review of Resident #110's Contropain medication used to treat modes she pulled a dose of Norco from the A.M.  A review of Resident #110's MAR ferometric given a dose of Norco on 10/12/22 given a dose of her PRN Norco on Record/ Disposition Form.  A review of the facility's investigation reviewed as a like resident related facility reviewed other residents nate Resident #110's. The resident's Co (Hydrocodone- Acetaminophen) 5- resident on 10/12/22 at 5:52 A.M. be Disposition Form by RN #125 was evidence the Norco had been actual the facility's investigation included conversation with LPN #112 who in medication prior to the resident's divere many times she did not received having been given on the Controlle the same written statement he reacetal the controlle the same wr	ed medical record revealed the resider e presence of a left artificial knee joint  am Data Set (MDS) 3.0 assessment, desues as she was able to make herself in revealed the resident was also noted ehaviors. The resident was assessed that it's worst. The assessment revealed as a revealed a care plan, dated 10/05 ament. The goal was for the resident to relieved pain. Interventions included a relieved pain in the resident of the resident of the resident of the resident of the relieved pain medication supply on 10/12.  The controlled medication supply on 10/12. The relieved pain medication count sheets as a recotic pain medication	and aftercare following joint  ated 10/13/22 revealed the resident understood and was able to to be cognitively intact and was a have complaints of frequent pain the pain did not affect her sleep or administering pain medication as in place to receive Hydrocodone-(PRN) for a pain level between  Form for her Norco (a narcotic revealed RN #125 documented 2/22 at 1:44 A.M. and again at 5:52  By documented the resident was ad evidence of the resident being at the Controlled Drug Receipt/  28015 revealed Resident #110 was ppropriation of medications. The part of their investigation to include tion Form for her Norco oted to have been given to the e Controlled Drug Receipt/ Record/our 2022 MAR to show documented as a #110 about her PRN pain ported Resident #110 told her there eving what was documented as orm. The Administrator indicated in sions but was unable to reach her

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F 0602  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	A review of a Performance Improvement Form for RN #125, dated 10/20/22 revealed she received corrective action on that date for the improper wasting of a narcotic. It was found by the DON during the course of a facility investigation into another resident's allegation of misappropriation of medication and was confirmed by RN #125 during her interview on 10/20/22 at 9:00 A.M.  On 11/02/22 at 8:27 A.M., an interview with LPN #112 revealed she recalled one morning when Resident			
	#110 had asked her for a PRN narcotic pain pill. She checked the MAR and it showed RN #125 had giver the resident her last dose of Norco around 1:00 A.M. When she looked at the Controlled Drug Receipt/ Record/ Disposition Form it showed a dose of the medication had been signed out around 1:00 A.M. and again around 5:00 A.M. She informed the resident the records showed she received a Norco tablet around 5:00 A.M. that morning based on what was documented by RN #125, however the resident denied that she had been given that dose.			
	On 11/02/22 at 2:50 P.M., an interview with the DON revealed Resident #110's narcotic pain medication (Norco) was improperly wasted by RN #125 on 10/12/22 at 5:52 P.M. The DON stated the Norco had be signed out on the Controlled Drug Receipt/ Record/ Disposition Form but was struck out on the MAR. R #125 reported she did not administer the Norco and wasted it instead. The destruction or wasting of that controlled medication was not witnessed by another nurse.  On 11/02/22 at 5:38 P.M., an interview with the DON revealed the dose of Norco that was signed out or Controlled Drug Receipt/ Record/ Disposition Form for 10/12/22 at 5:52 A.M. by RN #125 could not be accounted for, since it was not signed off on the MAR for October 2022 as having been given. She confiner investigation determined the Norco was signed out and marked on the MAR but had been struck out was no longer recorded to show it had been received. She stated their interview with RN #125 revealed had wasted the Norco when it was not given to the resident. The nurse did not have another nurse with the destruction of that medication as was required when disposing of a controlled medication. She acknowledged, since the narcotic pain medication had been signed out on the Controlled Drug Record was not documented as having been given on the MAR, the medication was misappropriated as it could be shown it was given to the resident as intended for. They could not show evidence of the controlled medication being wasted as it was not documented as having been wasted nor was there a witness acc by another nurse to prove that it was. She confirmed RN #125 was associated with the suspected misappropriation of another resident's PRN narcotic pain medication.			
	This deficiency represents non-con Number OH00136889 and Control	npliance investigated under Complaint Number OH00136939.	Number OH00136857, Control	

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
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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 0688  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate care for a residend/or mobility, unless a decline is  **NOTE- TERMS IN BRACKETS IN Based on observation, record revie ensure Resident #28 received appropriate Resident #38 received restoratives reviewed for position/range of motification including include:  1. Medical record review revealed including unspecified fracture of short Review of the Minimum Data Set (Indental Status (BIMS) score of 13 (Invesident had no behaviors or reject two-person assistance with person the resident did not receive restoral Review of the care plan, dated 10/4 with an intervention for an elastic with an intervention for an elastic with Review of the physician's orders refor stabilization of the wrist, every so the care plan, dated 10/4 with an intervention for an elastic with an intervention for an elastic with an intervention of the wrist, every so the physician's orders refor stabilization of the wrist, every so the provided in the past weak on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.  During interview on 11/01/22 at 2:54 P. as ordered.	dent to maintain and/or improve range of for a medical reason.  MAVE BEEN EDITED TO PROTECT Complete services to maintain range of more review repriate services to maintain range of more review. This affected two residents (# on and mobility.  Resident #28 was admitted to the facility aft of left humerus, hypertension, atrial MDS) 3.0 assessment, dated 08/06/22 out of 15), which indicated intact cognition of care. The MDS further revealed all hygiene, bed mobility, and transferstive nursing services or splinting.  19/22 revealed Resident #28 would be wrist brace, to right wrist, as tolerated.  Evealed an order, dated 10/18/22 for an shift.  14/28 was observed without the elastic more more representation of the provided and the services. STNA #51 stated she did to the provided and the provided representation of P.M., State tested Nursing Assistant elastic brace. STNA #51 stated she did to the provided representation of P.M., Decupational Therapist (OT) # the brace to Resident #28's nurse to a story. The DON verified the wrist brace and the wrist brace and the wrist brace.	of motion (ROM), limited ROM  ONFIDENTIALITY** 33019  and interview the facility failed to notion/mobility and failed to ensure 28 and #38) of five residents  ty on [DATE] with diagnoses fibrillation, and muscle weakness.  revealed a Brief Interview for tion. The assessment revealed the Resident #28 required extensive, The MDS assessment revealed  able to improve functionality to arm elastic wrist brace to the right wrist wrist brace in place. During not wearing an elastic wrist brace  (STNA) #51 confirmed Resident d not know there was an order for a will will be a served him to be wearing one during 144 stated the wrist brace arrived pply to the resident #28 was not

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
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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 0688  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	s's plan to correct this deficiency, please contact the nursing home or the state survey agency.  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)  45440		mitted to the facility on [DATE] with ditary spastic paraplegia, essential dent #38 was cognitively intact and ditoileting and total dependence be MDS also revealed Resident #38 and not receiving any restorative defeated for the most of the most

			10. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
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F 0688  Level of Harm - Minimal harm or potential for actual harm	Review of the facility policy titled, Restorative Nursing Programs, dated 01/01/22 revealed the goal(s) of restorative nursing included improving and/or maintaining independence in activities of daily living and mobility. The policy defined Level Two Restorative Nursing as a reasonable expectation that improvement would continue to occur with resident participation and goal setting.		in activities of daily living and
Residents Affected - Few	This deficiency represents non-con	npliance investigated under Complaint	Number OH00137086.

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Arbors at Marietta		400 Seventh Street Marietta, OH 45750	
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(X4) ID PREFIX TAG	(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689	Ensure that a nursing home area is accidents.	s free from accident hazards and provid	les adequate supervision to prevent
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 28923
Residents Affected - Few	Based on observation, record review, review of facility fall investigations, facility policy and procedure revier and interview the facility failed to ensure Resident #92 received the appropriate level of assistance during a transfer and had proper footwear on at the time of the transfer to prevent an avoidable fall. The facility also failed to develop a comprehensive and individualized fall prevention program for Resident #41 and failed to ensure comprehensive fall investigations were completed to identify the root cause of falls so appropriate interventions could be initiated to prevent additional falls from occurring for the resident. This affected two residents (#41 and #92) of four residents reviewed for falls and/or accident hazards.		
	Findings include:		
	A review of Resident #92's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a stroke affecting the left non-dominant side unsteadiness on her feet, abnormalities of gait and mobility, muscle weakness, and difficulty walking.  A review of Resident #92's active care plans revealed a plan of care initiated on 02/11/22 reflecting the resident was at risk for falls related to decreased safety awareness. The resident denied having had a strok and having the inability to ambulate. Interventions included anticipating/ meeting the resident's needs base on nursing assessments.		
A review of Resident #92's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04 resident did not have any communication issues and her cognition was moderately impair assessment revealed the resident's vision was adequate with the use of corrective lenses known to have any behaviors and was not known to reject care. The assessment reveale required extensive assistance from two staff for transfers and toilet use and ambulation d Balance issues were noted when going from a seated to a standing position and with surf transfers requiring physical help from staff to stabilize. The resident exhibited functional li range of motion to the upper and lower extremity on one side. The resident was not indicating any falls since her entry into the facility or since the prior assessment.			
	A review of Resident #92's progress notes revealed an incident note for 05/08/22 that indicated the re was assisted to the floor by staff. The note indicated a State tested Nursing Assistant (STNA) was hel the resident transfer into bed when the resident started sliding. The STNA assisted the resident to the The resident was wearing regular socks and was not wearing proper footwear when she was being transferred. The intervention added was to ensure the resident was wearing proper footwear when transferring to her bed and chair.		
	(continued on next page)		

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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	progress note. The resident was in the resident was not wearing prope wearing proper footwear when trans in the resident's room. STNA #500 time of her fall.  A subsequent quarterly MDS 3.0 a assist of two staff for transfers. The injury.  On 11/03/22 at 1:31 P.M., an internous Resident #92 had to be lowered to assisting the resident with during the hamstring as a result of that income to her bed. She denied she had an revealed when she stood the resident effoor. She was questioned on the incident occurred. The STNA state was not sure how it was communic with transfers. She went by what she one person assist with transfers. Shopper footwear on at the time of the the resident had proper footwear on was the only STNA on the floor at that she could have asked for assis resident's transfer as the nurse was considered as a result of he resident's transfer on 05/08/22 was identified her as requiring a two percould not be considered an unavoic by staff and not having the appropriation of the facility policy on Fa assessed for the risk of falling and minimize the likelihood of falls. The also considered a fall. A near miss the resident from doing so. The facility resident from doing so.	view with Director of Nursing (DON) rever not having proper footwear on at the sperformed by one STNA, when the reson assist with transfers. The DON active dable fall due to her not having proper riate assistance level when being transful Il Prevention Program, revised 01/01/2 would receive care and services in acceptable process of a fall towas when a resident would have faller stillity would use a standardized risk asserisk factors and environmental hazards	cor by staff. Mitigating factors was was to ensure the resident was curred at 10:15 P.M. and occurred to transferred the resident at the resident remained an extensive me fall with injury that was not major recident as she stated she pulled and the resident from her wheelchair with the transfer. The STNA de so she lowered the resident to de for transfers at the time the required a one person assist. She level a particular resident was to be a required a one person assist. She level a particular resident was to be a required a one person assist. She level a particular resident was to be a required a one person assist. She level a particular resident was to be a required a one person assist. She level a particular resident was to be a required a one person assist. She level a particular resident was to be a required a one person assist. She level a particular resident was to be a reduced the resident was to be a required a one person assist. She level a particular resident was to be a required a fall the resident was a valiable on the unit define of the fall. She confirmed the sident's prior MDS assessment knowledged the fall on 05/08/22 footwear on while being transferred ferred from her chair to bed.  2 revealed each resident would be cordance with the level of risk to on include a near miss which was a if someone else had not caught tessment for determining a

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	diffuse traumatic brain injury with lo lupus anticoagulant, and cognitive  Record review revealed a plan of common traumatic brain injury. Interventions alarms were functioning and in place an STNA. The resident appeared to resident's bed alarm was not in place alarm to bed and placed a new alace cause of the fall. Staff were educated Review of Resident #41's fall risk ecompleted after the fall that occurred Review of Resident #41's Minimum required extensive assistance from transfers.  Review of Resident #41's fall investigation of Review of Resident #41's fall risk ecompleted after the fall that occurred Review of Resident #41's fall investigation of Review of Resident #41's fall risk ecompleted after the fall that occurred Review of Resident #41's fall investigation of Review of Resident Review of Review of Resident Review of Review of Resident Review of Resident Review of Review of Resident Review of R	are, (initiated 08/17/20) related to the resincluded (on 07/21/22 and revised 10/22 and (09/08/22) ensure mattress was stigation, dated 07/20/22 indicating Responsive and was found underneath the resident on electric chair. There was no evided on the placement of alarms and funded on 07/20/22.  In Date Set (MDS) 3.0 assessment, date two for dressing and bed mobility and tigation, dated 09/19/22 revealed the remself around in the bed so that his heat etermined a root cause of the fall.  Invaluations revealed there was no evidence on 09/19/22.  It gation, dated 09/19/22 revealed the remself around in the bed so that his heat etermined a root cause of the fall.  Invaluations revealed there was no evidence on 09/19/22.  It gation, dated 10/04/22 revealed the remained around in the bed so that his heat etermined a root cause of the fall.  It gation, dated 10/04/22 revealed the remained around in the bed so that his heat etermined a root cause of the fall.  It gation, dated 10/04/22 revealed the remained around the resident was no evidence the facility of the resident was no evidence to be high rismand the resident displayed no behaviors, requiring the properties of the resident was noted to be high rismand the resident displayed no behaviors, requiring the resident displayed no behaviors, requiring the resident was noted to be high rismand the resident displayed no behaviors, requiring the resident was noted to be high rismand the remaining the resident was noted to be high rismand the remaining the remainin	remiparesis, aphasia, apraxia, resident's history of falls and r10/22) to ensure chair and bed resecurely fastened to bed frame.  rident #41 was found on the floor by right investigation revealed the resident's Dycem in the chair. Returned rence the facility determined a root rection.  rence a new fall risk evaluation was red 09/02/22 revealed the resident resident was totally dependent on staff for resident was lying on the mat next to red was at the bottom. There was no rence a new fall risk evaluation was resident was found crawling on the red determined a root cause of the red assistance with elimination, was reg movement.  d STNA revealed interventions were red thad no bed or chair alarm. The

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, Z	IP CODE
Arbors at Marietta		400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 11/03/22 at 11:11 A.M. observathe resident's mattress was not strathe intervention to secure the mattress of care. The staff members revealed scoot his body.  On 11/01/22 at 3:03 P.M. interview fallen out of bed four times even the no reason the resident should be factor of the	ation of Resident #41 with STNA #16 a apped/secured to the bed. Staff reporter the sess to the bed frame should probably bed the resident was not able to physical with Resident #41's mother revealed sough he was unable to move much. The alling out of bed.  5 A.M. interview with the Director of Normal 10/04/22 were not thoroughly investigated after the falls that occurred on the were supposed to be completed after in revised on 10/11/22 when the alarms one and no longer required to be secured in the likelihood of falls.  Tampolicy, dated 10/20/20 and revised alling and would receive care and service the likelihood of falls.  Fram policy, dated 10/20/20 and revised alling and would receive care and service the secure the likelihood of falls.  Fram policy dated 10/20/20 and revised alling and would receive care and service the secure the likelihood of falls.  Fram policy and the secure care and service the secure the likelihood of falls.  Fram policy and the secure care and service the secure the sec	and Unit Manager (UN) #65 revealed and it was a new mattress and that have been removed from the plan and the plan and the plan are resident's mother felt there was a ursing (DON) verified Resident are resident's mother felt there was a ursing (DON) verified Resident are resident and the root cause and the plan are plan and the root cause are plan and the root cause are plan and the root felt and the root cause are discontinued or when the root to the bed frame.  The plan are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022	
NAME OF PROMPTS OF CURRULES		CERTAIN ARREST CITY CTATE 71	D CODE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street	PCODE	
Arbors at Marietta	Arbors at Marietta			
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state		tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0697	Provide safe, appropriate pain mar	nagement for a resident who requires s	uch services.	
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 28923	
Residents Affected - Few	Based on closed record review, review of a facility self-reported incident (SRI) and the facility related investigation, review of controlled drug record/disposition forms and staff interview the facility failed to ensure Resident #86 was provided an adequate and effective pain management program, including the administration of as needed (PRN) narcotic pain medication as requested and to meet the resident's pain and total care needs.			
	Actual Harm occurred beginning on 10/11/22 when Resident #86 requested the ordered narcotic pain medication (Percocet) but was administered Colace (a stool softener) in place of the medication resulting in the resident having increased bowel movements during the night, increased pain and an inability to sleep. Subsequent requests by the resident for the Percocet from the same nurse (Registered Nurse (RN)) #125 resulted in additional doses of Colace being administered and not the Percocet as ordered resulting in unrelieved pain for the resident.			
	This affected one resident (#86) of	three residents reviewed for misapprop	oriation of property.	
	Findings include:			
	A review of Resident #86's closed medical record revealed the resident was originally admitted to the facility on [DATE] with a readmitted [DATE]. The resident had diagnoses including a left femoral neck fracture (hip fracture), low back pain, and the presence of bilateral artificial hip joints. Record review revealed the resident was discharged home on 10/24/22.			
	A review of Resident #86's admission Minimum Data Set 3.0 (MDS) assessment, dated 07/14/22 revealed the resident did not have any communication issues as he was able to make himself understood and was able to understand others. The assessment revealed the resident was cognitively intact and was not know to display any behaviors. A pain assessment revealed the resident did report having pain in the last five days. The MDS assessment noted the pain did not affect his sleep at night but did limit his day-to-day activities.			
	A review of Resident #86's care plans revealed a plan of care, initiated 10/01/22 related to the resident's for pain related to a left hip fracture, osteoarthritis, low back pain, and spinal stenosis. The goal was for t resident to have adequate pain control and for him to verbalize adequate relief of pain or the ability to co with incompletely relieved pain. The interventions included administering his pain medications as ordered			
	A review of Resident #86's physician's orders revealed the resident had an order in place to receive Per (a controlled narcotic pain medication used in the treatment of moderate to severe pain) 5- 325 mg table with directions to give one tablet by mouth every six hours PRN for pain rated a three to six on a 1-10 so The instructions indicated two tablets could be given for pain levels between a seven and 10 on a 1-10 so			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF DROVIDED OR SURDIUS	NAME OF PROVIDER OR SURPLIER		D CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street	PCODE
Arbors at Marietta		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.			agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0697		tion administration record (MAR) for Oc	
Level of Harm - Actual harm	of 10/11/22 into the morning of 10/	dent his PRN Percocet twice during he 12/22 and again the evening of 10/12/2	2 going into the morning of
Residents Affected - Few		itions of the PRN Percocet, RN #125 d	•
Residents Affected - Pew	two of the 5-325 mg tablets with each dose given. The two tablets of Percocet that were documented as having been given to the resident on 10/11/22 at 10:20 P.M. did not follow the parameters set forth by the physician on when to administer the PRN Percocet. The resident's pain level was recorded as only being a 2 on a 1-10 scale at the time of the administration. The physician's orders did not permit the PRN Percocet to be given unless the resident's pain level was a 3 or higher. The resident was only to receive two tablets of the PRN Percocet when his pain level was 7 or higher. RN #125 did not follow the parameters specified with the physician's orders again on 10/13/22 at 6:07 A.M. when she documented she gave two Percocet 5- 325 mg tablets for a pain level of a 6 on a 1-10 scale. Documentation on the MAR and Controlled Drug Record/ Disposition form included RN #125 administered a total of four Percocet tablets the night of 10/13/22.		
	A review of facility self-reported incident (SRI), tracking number 228015 revealed an allegation of misappropriation of resident property was made on 10/13/22. The initial source of the allegation was from Resident #86, who was identified to be the resident victim. Resident #86 was noted to have been able to provide meaningful information when interviewed and the effect the incident had on the resident was reports of diarrhea. The alleged/ suspected perpetrator was a staff member not identified in the initial report.		
	The final report for SRI tracking number 228015 revealed the date/ time/ location of the occurrence was on 10/13/22 at 5:40 A.M. in the resident's room. The narrative summary of the incident revealed the facility Administrator was made aware Resident #86 was concerned he was given the wrong medication in place of his prescribed pain medication by RN #125. As a result, the resident did not take the medication and sat it to the side, so the oncoming day shift nurse could see what he had been given. Shortly after 7:00 A.M., Resident #86 called for Licensed Practical Nurse (LPN) #112 to come to his room. He showed the nurse the pills that had been given to him that night by RN #125 as his PRN pain (Percocet) medication.		
	Colace 100 mg capsules and not h Administrator's attention and an inv the investigation. Resident #86's pl was determined the resident did no scheduled or a PRN basis. Statem facility's investigation. The local po- controlled narcotic pain medication conclusion of their investigation ind	confirmed the pills Resident #86 receive is PRN Percocet ordered for pain. The vestigation began with RN #125 being so the property of the pro	information was brought to the suspended pending the outcome of t of the facility's investigation, and it olace 100 mg capsules on a and LPN #112 as part of the the alleged misappropriation of atton of misappropriation at the although misappropriation was

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street Marietta, OH 45750	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0697 Level of Harm - Actual harm Residents Affected - Few	resident reported in his statement to for pain and he did not get any relia informed another nurse about it (LF were given to him and told him what the same pain pills he was familiar 10/13/22, the resident indicated he right. The nurse took them back, lo come from a new box. He had to prout of his mouth.  A witness statement from LPN #11 that he did not know what the night Resident #86 informed LPN #112 reported to her that he was using the then, but the resident declined. The medication. LPN #112 stated she to the identifying numbers on them as would clear things up and prove he resident kept his pills he was given morning of 10/13/22. The nurse indicated the her shift from the evening of 10/12/give him his pain medication. She agone to the bathroom, so she gave  The facility's investigation file also in 10/27/22 that revealed the facility's about RN #125. A description of the misappropriation. Their investigation termination from employment. The indicated to have had pain manage indicated to have received the wron was signed off as having been administered a medication (Colace reported he was given the wrong more revealed the nurse gave Colace to	on revealed a witness statement from Rehe night before (10/11/22- 10/12/22) the from his pain after taking the pills not on the tolook for. The resident alleged he has with receiving. The evening of 10/12/2 informed the nurse (RN #125) the pills oked at them, and handed them back to them in his mouth under his tongue of the tolook at them in his mouth under his tongue of the was in pain all night (10/11/22- 10/12) are bathroom all night to defecate. She are resident remained adamant he did not old the resident to look at his pills then as his PRN Percocet did then they were awas getting the proper medication. She the next night (10/12/22) as his PRN pilotated in her witness statement that wis sident requested to file a complaint.  To the facility's Administrator, sent 10/12/22 to the morning of 10/13/22, she woll also gave the resident stool softeners as him two stool softeners after his pain included a complaint form to the State of Director of Nursing (DON) filed a complaint or violation revealed RN # in revealed violations of three company involved resident was mentioned in the ment issues related to the practice bready medication and reported he did not inhinistered to him. The DON indicated in that kept him up all night. The involved of without a physician's order to do so. The resident without an order, inappropon record (MAR's) at the correct times, and the correct times.	the nurse (RN #125) gave him pills of did they make him sleep. He sheck his pills the next time they ad received four pills that were not 2 going into the morning of a she was giving him did not look to him while telling him they had until she left and then he took them to the that it was not his pain pills. 2/22) and could not sleep. He also offered for him to file a complaint of treceive the proper pain leext time and if they did not have not his pills. The nurse hoped that he stated, however, it did not. The pain medication and showed her the nat was given to the resident were also had told her earlier he had not medication.  To Ohio Board of Nursing, dated plaint with the Board of Nursing 125 had been suspended for a policies that resulted in her a complaint and the resident was receive the pain medication that to harm occurred to the resident or have also indicated to have the DON added the resident pain medication. Their investigation or a policies of the pain medication related to

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Arbors at Marietta		400 Seventh Street Marietta, OH 45750	PCODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0697 Level of Harm - Actual harm Residents Affected - Few	included in the facility's investigation Percocet twice on the evening of 10 10/12/22 going into the morning ho two tablets of Percocet (Oxycodone four tablets each of the two shifts.  On 11/02/22 at 8:27 A.M. interview about three weeks ago. The resider reported to administration) he did not requested and the resident suspect showed the resident what his PRN correct medication. The next morning resident had four stool softeners to requested his Percocet pain medications PRN Percocet. She denied the before (10/11/22- 10/12/22), the resident had four it before it being addicapsules each time he asked for his PRN Percocet (the morning of 10/1 his PRN Percocet (the morning of 10/1 his PRN Percocet when he did not different because they came out of from his usual PRN pain medication were not the same that he had received the pain medications. LPN #112 was the first not have immediate concerns where aware LPN #112 showed the reside was wrong, he would know. On the requested pain medication and RN # medication and he informed her that telling him they came in a new box after she left the room. LPN #112 to LPN #112 the medication was not he capsules of Colace were shown to reported the incident to the Administ	with the facility Administrator and Directigation of SRI tracking number 22801 PRN Percocet. Resident #86 thought to the to hear about the resident's concerns it was first brought to her attention. Then what his Percocet looked like so in evening of 10/12/22 going into 10/13/2 £125 brought medication into him that to go the first brought with the service of the medication urame in around 7:00 A.M. that morning given to him by RN #125 as his PRN pois Percocet but was Colace instead. The LPN #112 that morning. It was after this trator. Witness statements were obtaing an investigation. The Administrator resident placed the Administrator resident placed.	the gave the resident his PRN f 10/12/22 and again the evening of to reflect she gave the resident ag) at each administration totaling a wolving Resident #86 happened a day before the incident was the shift nurse (RN #125) as he instead. The LPN stated she ad whether he was being given the the resident asked to see her. The sent to him by RN #125 after he had ent was given was Colace and not a c. The LPN revealed the night pain and had to go to the RN basis and the resident would lent was given two Colace resident was supposedly given his got two more Colace in place of tedly told (by RN #125) they looked titioned why they looked different ercocet given to him by RN #125 cotor of Nursing (DON) revealed 5 and RN #125's alleged things did not seem right with his a (on 10/11/22), but stated she did the Administrator and DON were the event he thought something 22, the resident reported he didn't look right. He placed the came in again with his PRN pain them then gave them back to him ander his tongue and removed them as the day shift nurse. He showed ain medication. LPN #112 verified the Administrator confirmed four is second night that LPN #112 and and a SRI was initiated. The

			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street Marietta, OH 45750	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0697 Level of Harm - Actual harm Residents Affected - Few	This deficiency represents non-con Number OH00136889 and Control	npliance investigated under Complaint Number OH00136939.	Number OH00136857, Control

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER  Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street Marietta, OH 45750	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide pharmaceutical services to licensed pharmacist.  **NOTE- TERMS IN BRACKETS In Based on record review, facility sell procedure review, review of Control count sheets and interview the facility failed to ensure controlled in administered to residents and propic completed to identify any discrepart available for administration from the #110) of three residents reviewed for reviewed for unnecessary medicating include:  1. A review of Resident #86's close [DATE] with diagnoses including a back pain.  A review of Resident #86's physicial (a narcotic pain medication used in mouth every six hours as needed (or two based on the resident's pain three and six on a 1-20 scale and the A review of Resident #86's Control tablets revealed the resident was prontracted pharmacy. The receipt of but was not signed by the nurse which but was not signed by the nurse which is tarted signing out doses from that the A review of the narcotic shift count facility) revealed the off going nurse the controlled medication cards on discrepancies between the two which is the controlled medication cards on discrepancies between the two which is the controlled medication cards on discrepancies between the two which is the controlled medication cards on discrepancies between the two which is the controlled medication cards on discrepancies between the two which is the controlled medication cards on the cardian and the controlled medication cards on the cardian and the controlled medication cards on the cardian and the ca	AVE BEEN EDITED TO PROTECT Conference of incident review and related in solution of the provided incident review and related in solution of the provided incident review and related in solution of the provided incident review and related in solution of the provided incident	employ or obtain the services of a  ONFIDENTIALITY** 28923  nvestigation, facility policy and Forms, review of narcotic shift is were provided to residents as the needs of each resident. The ropriately documented when controlled medication were ed to ensure medications were three residents (#86, #102 and one resident (#2) of five residents  It was admitted to the facility on a translation and low the translation of the translat

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency places con	tact the nursing home or the state survey	agency
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	A review of facility self-reported inc misappropriation was made on 10/ allegation and a facility staff memb been able to provide meaningful in incident was 10/13/22 at 5:40 A.M. other than his ordered as needed (Nurse (RN) #125.  As part of the facility's investigation As a result of the facility's investigation As a result of the facility's investigation documentation were violated. The date of the facility's employee properties of the medication was been company policy related to the impurfound by the DON during the course employment as a result of those violated. The facility's investigation of the facility's investigation file number 228015. RN #125 was indimisappropriation. The investigation MAR's at the correct times and the violations of company policy.  On 11/02/22 at 5:38 P.M., an intervinvestigation of SRI tracking number and not having two nurses sign corfrom the pharmacy. She stated two received from the pharmacy. She stated two received from the pharmacy. She cannot be received from the pharmacy in the pharmacy of the received and on coming nurse should be received that the two nurses were accompand that the two nurses were accompand to the same as the remaining the same as the rem	ident (SRI) tracking number, 228015 re 13/22 by Resident #86. The resident wer was indicated to be the alleged victin formation when interviewed and the dain the resident's room. Resident #86 a PRN) pain medication (Percocet) for continuous pain medication, it was determined nursing policies involved nurse (RN #125) was terminated to have violated company policy resident of the investigation. The employee was pain pain medication. The employee has been experienced to have been suspended pendinated	evealed an allegation of as the initial source of the m. Resident #86 was noted to have te/ time/ occurrence of the alleged lleged he was given something omplaints of pain by Registered eresident and other like residents. In regard to medication and ted from employment.  Informance Improvement Form, painst the nurse for standards of lated to documentation not taking also indicated to have violated volving another resident that was and been discharged from  10/27/22 revealed RN #125 had (DON). The complaint form was for Resident #86's medication in SRI gan investigation into allegations of lumentation related to the signing of 25 was terminated based on three  was involved in the facility's entified concerns with controlled herolled medication was delivered introlled medication was delivered introlled medication had been to show two nurses had signed eralso reported the off going nurse ation cards that were in the tions as a means to ensure cording the cards to sheet count, it on to ensure the doses they had on ount of the controlled medication

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER  Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Seventh Street  Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	01/01/22 revealed it was the policy State and federal regulations regansafeguards in place in order to previous counted upon delivery. The nurse must count the controlled substance When a resident refused controlled destructions must be conducted in count controlled medications at the must make the count together. Doc 2. A review of Resident #110's clost facility on [DATE] with diagnoses in replacement surgery, and osteoarth A review of Resident #110's physic Acetaminophen (Norco) 5- 325 mg and 10 on a 1-10 scale.  A review of Resident #110's Control Norco 5-325 mg was signed out by A review of Resident #110's medication to document a dose of Norco was Receipt/ Record/ Disposition Form. additional doses was indicated as here found by the facility's DON dut to the misappropriation of medication of 11/02/22 at 2:50 P.M., an interview wasted a narcotic pain medication of allegation of misappropriation of his RN #125 had wasted a dose of Norbasis. She stated the nurse signed Disposition Form but had struck the dose but did not have the destruction of the struction	ian's orders revealed an order, dated 1 by mouth every four hours as needed olled Drug Receipt/ Record/ Disposition RN #125 on 10/12/22 at 5:52 A.M. ation administration record (MAR) for C given on 10/12/22 at 5:52 A.M. as was She did document a dose was given on aving been given by the nurse that nigersonnel file revealed she received coucy related to the improper wasting of nuring the course of the facility's investig	ality patient care, compliant with abstances. The facility would have sure. Controlled medications must be person delivering the medication, the designated narcotic record. The deciding shall be destroyed. All a pharmacist. Nursing staff must in duty and the nurse going off duty fit verification sheet.  The resident was admitted to the knee joint, aftercare following joint of the property of the property of the controlled Drug on 10/12/22 at 1:44 A.M. but no late. It was indicated to have ation into SRI #228015 pertaining the stated the facility determined to ordered on an as needed (PRN) de pruse told her she wasted the ed by another nurse. RN #125's

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE  400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SURPLUS		CTREET ARRESC CITY CTATE T	D 0005
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 con	tact 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 0755  Level of Harm - Minimal harm or potential for actual harm	Review of Resident #2's Medication Administration Records (MAR) and current orders for 10/2022 revealed the resident was ordered Lamictal 25 milligrams (mg) two tablets at bedtime for a diagnosis of bipolar disorder.		
Residents Affected - Some	Further review of MAR revealed the as it was not available from pharma	e resident did not receive the Lamictal acy.	on 10/29/22, 10/30/22 or 10/31/22
	Review of Resident #2's progress r was not available or administered u	notes revealed the resident's physician until 11/01/22.	was not notified the medication
	entered incorrectly as 25 mg, one to pharmacy system was kicking out to didn't affect the facilities orders. The resident did not receive the medical need to do a medication error repor-	with the Director of Nursing (DON) reablet at bedtime instead of two tablets he orders and the pharmacy was having a DON confirmed the physician was notion on 10/29/22. 10/30/22 or 10/31/22 or and do immediate staff education regard-compliance investigated under Continuous compliance investigated under Continuous complianc	at bedtime. The DON reported the ng to re-enter them; however, it of notified until 11/01/22 the . The DON reported she would garding the incident.

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIE	NAME OF DROVIDED OR SURDIJED		P CODE
Arbors at Marietta			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0805  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF DROVIDED OD SUDDI II		STREET ADDRESS SITV STATE 71	D CODE
NAME OF PROVIDER OR SUPPLIE	=R	STREET ADDRESS, CITY, STATE, ZI 400 Seventh Street	PCODE
Arbors at Marietta	Arbors at Marietta		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0919	Make sure that a working call syste	em is available in each resident's bathr	oom and bathing area.
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 45440
Residents Affected - Few	Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure Resident #52's call signal device was in proper working order. This affected one resident (#52) of six residents reviewed for physical environment.		
	Findings include:		
	Review of Resident #52's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, benign prostatic hyperplasia, and generalized muscle weakness.		
	Review of Resident #52's annual Minimum Data Set (MDS) 3.0 assessment, dated 09/02/22 revealed the resident was cognitively impaired and required supervision with (staff) set up assistance only for eating.		
	On 10/31/22 at 2:30 P.M. observation of Resident #52's call signal device revealed the device did not activate when the button was pushed.		
	On 11/02/22 at 8:50 A.M. observation revealed Resident #52's call signal device did activate when the button was pushed. The resident was observed to attempt to activate the call light twice. Interview with Maintenance Director (MD) #116, who was present at the time of the observation revealed staff from the maintenance department check three resident call lights every morning and by the end of the month all call lights would have been assessed. MD #116 verified Resident #52's call signal device was not properly functioning and the resident could not use the call device for seek assistance from staff due to it not working.		
	On 11/03/22 at 10:58 A.M. an interview with Licensed Practical Nurse (LPN) #9 revealed Resident #52 was lucid at times and would be able to use his call light if assistance was needed.		
	On 11/03/22 at 10:59 A.M. an interview with State tested Nursing Assistant (STNA) #69 revealed Resident #52 could use his call light and had used it in the past to get staff assistance.		
	revealed the purpose of the policy	Call Lights: Accessibility and Timely Resewas to ensure the facility was adequate ng facility to allow residents to call for a	ely equipped with a call light at each
	•		