STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365687	A. Building B. Wing	11/15/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440 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 to 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 with bed 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 not 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 a 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 injuries. Two examples of call devices for residents with brain injuries he provided were a flat one which a resident would hit with their hand and one the resident could activate by moving their head. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/02/22 at 9:18 A.M. interview with Licensed Practical Nurse (LPN) #94 verified Resident #6 did not have a call signal device she could use and there had not been an assessment completed to evaluate what call device would work or be most appropriate for the resident to summon assistance from staff. On 11/02/22 at 9:21 A.M. interview with Registered Nurse (RN) #56 revealed Resident #6 could move a couple of fingers on her right hand and move her head. On 11/02/22 at 9:41 A.M. LPN #94 was observed to provide Resident #6 with a flat call device that was activated by tapping it. Resident #6 was observed to be able to activate the call device when LPN #94 asked her to. On 11/02/22 at 9:43 A.M. interview with RN #56 verified there were no orders in Resident #6's medical record to check her more frequently than every two hours with turning and checking and nothing in the care plan regarding checks more frequently than every two hours with turning and repositioning. RN #56 verified with no call device to activate, Resident #6 could not notify staff of an emergent or non-emergent need for assistance. Review of the facility policy titled Call Lights: Accessibility and Timely Response, reviewed/revised 01/01/22 revealed each resident would be evaluated for unique needs and preferences to determine any special accommodations that might be needed in order for the resident to utilize the call system. Special accommodations would be identified on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to 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 good 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 heart 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 12/08/21. 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 that contained two books, Depends, tapes, jewelry and a death book. The resident stated she had to move to E 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 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 the previous Administered had addressed the issue. The DON confirmed the resident's concern was not listed on the facility concern log and stated she would look to see if the previous Administer might have written anything on paper. The DON revealed the previous Administrator left the facility in June 2022. On 11/02/22 at 8:28 A.M. interview with the current (Interim) Administrator revealed he could not find any 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 not 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)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. a. On 10/31/22 at 2:43 P.M. and 11/02/22 at 8:46 A.M. observation of Resident #72's wall behind the resident's bed and to the left of the bed revealed large white patched areas in need of being painted. On 11/02/22 at 8:46 A.M. observation of the area with Maintenance Director (MD) #116 verified the wall was not in good repair and needed painted. b. On 10/31/22 at 10:58 A.M. observation of Resident #27's wall behind her bed revealed a large white patched area in need of being painted. On 11/02/22 at 8:50 A.M. observation of the area with MD #116 verified the wall was not in good repair and needed painted. c. On 10/31/22 at 3:11 P.M. observation of Resident #60's over bed table revealed the table had rough edges. Interview with Resident #60 at the time of the observation revealed the table had been like that for a while. Resident #60 reported it was rough on her arms and sometimes she would scratch herself on the table. On 11/02/22 at 8:48 A.M. observation with MD #116 verified the table was in disrepair and Resident #60 needed a new over bed table. Review of an over bed table audit completed by the facility revealed 19 residents, Resident #3, #5, #10, #23, #27, #32, #39, #47, #59. #60, #67, #71, #74, #91, #93, #98, #101, #106, and #260 had over bed tables which were in disrepair and needed replaced. Review of the facility policy titled Safe and Homelike Environment, reviewed/revised 01/01/22 revealed in accordance with residents' rights, the facility would provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 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 Percocet (a controlled narcotic pain medication used in the treatment of moderate to severe pain) 5- 325 milligrams (mg) with directions to give one tablet by mouth every six hours as needed (PRN) for pain rated a three to six on a 1-10 scale. The instructions indicated two tablets could be given for pain levels between a seven and 10 on a 1-10 scale. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #86's medication administration record (MAR) for October 2022 revealed RN #125 documented administering the resident his PRN Percocet twice during her night shift going from the evening of 10/11/22 into the morning of 10/12/22 and again the evening of 10/12/22 going into the morning of 10/13/22. During all four administrations of the PRN Percocet, RN #125 documented she gave the resident 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 indicated 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. Upon further investigation, it was confirmed the pills Resident #86 received were actual stool softener, Colace 100 mg capsules and not his PRN Percocet ordered for pain. The information was brought to the Administrator's attention and an investigation began with RN #125 being suspended pending the outcome of the investigation. Resident #86's physician's orders were reviewed as part of the facility's investigation, and it was determined the resident did not have a physician's order to receive Colace 100 mg capsules on a scheduled or a PRN basis. Statements were obtained from Resident #86 and LPN #112 as part of the facility's investigation. The local police department were also informed of the alleged misappropriation of controlled narcotic pain medication. The facility unsubstantiated the allegation of misappropriation at the conclusion of their investigation indicating the evidence was inconclusive, although misappropriation was suspected. RN #125 was terminated from employment but was terminated due to nursing policies in regard to medication and documentation being violated. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's investigation revealed a witness statement from Resident #86 was obtained. The resident reported in his statement the night before (10/11/22- 10/12/22) the nurse (RN #125) gave him pills for pain and he did not get any relief from his pain after taking the pills nor did they make him sleep. He informed another nurse about it (LPN #112) and she encouraged him to check his pills the next time they were given to him and told him what to look for. The resident alleged he had received four pills that were not the same pain pills he was familiar with receiving. The evening of 10/12/22 going into the morning of 10/13/22, the resident indicated he informed the nurse (RN #125) the pills she was giving him did not look right. The nurse took them back, looked at them, and handed them back to him while telling him they had come from a new box. He had to put them in his mouth under his tongue until she left and then he took them out of his mouth. A witness statement from LPN #112 revealed Resident #86 had reported to her the morning of 10/12/22 he did not know what the night shift nurse (RN #125) had given him, but that it was not his pain pills. Resident #86 informed LPN #112 he was in pain all night (10/11/22- 10/12/22) and could not sleep. He also reported to her that he was using the bathroom all night to defecate. She offered for him to file a complaint then, but the resident declined. The resident remained adamant he did not receive the proper pain medication. LPN #112 stated she told the resident to look at his pills the next time and if they did not have the identifying numbers on them as his PRN Percocet did then they were not his pills. The nurse hoped that would clear things up and prove he was getting the proper medication. She stated, however, it did not. The resident kept the pills he was given the next night (10/12/22) as his PRN pain medication and showed LPN #112 the morning of 10/13/22. The nurse indicated in her witness statement that what was given to the resident were stool softeners. At that time, the resident requested to file a complaint. A review of an email from RN #125 to the facility's Administrator, sent 10/20/22 at 10:36 A.M. revealed, on her shift from the evening of 10/12/22 to the morning of 10/13/22, she woke Resident #86 that morning to give him his pain medication. She also gave the resident stool softeners as he had told her earlier he had not gone to the bathroom, so she gave him two stool softeners after his pain medication. A review of RN #125's employee file revealed a Performance Improvement Form dated 10/20/22. The form indicated the RN had a hire date of 02/28/20. The reason for counseling/ corrective action was for violating company policy related to medications given without a physician's order, which was verified by RN #125 during an interview on 10/20/22. Documentation was also not taking place at the time medication was being administered. There was also the improper wasting of a narcotic pain medication of another resident found by the DON during the course of Resident #86's investigation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation file also included a complaint form to the State of Ohio Board of Nursing, dated 10/27/22 that revealed the facility's Director of Nursing (DON) filed a complaint with the Board of Nursing about RN #125. A description of the complaint or violation revealed RN #125 had been suspended for misappropriation. Their investigation revealed violations of three company policies that resulted in her termination from employment. The involved resident was mentioned in the complaint and the resident was indicated to have had pain management issues related to the practice breakdown. The resident was indicated to have received the wrong medication and reported he did not receive the pain medication that was signed off as having been administered to him. The DON indicated no harm occurred to the resident despite him having unrelieved pain that kept him up all night. The involved nurse was also indicated to have administered a medication (Colace) without a physician's order to do so. The DON added the resident reported he was given the wrong medication when he asked for his PRN pain medication. Their investigation revealed the nurse gave Colace to the resident without an order, inappropriate documentation related to signing the medication administration record (MAR's) at the correct times, and improper waste of a narcotic medication. A review of a Controlled Drug Receipt/ Record/ Disposition form for Resident #86's Percocet that was included in the facility's investigation file revealed RN #125 documented she gave the resident his PRN Percocet twice on the evening of 10/11/22 going into the morning hours of 10/12/22 and again the evening of 10/12/22 going into the morning hours of 10/13/22. Both times she signed to reflect she gave the resident two tablets of Percocet (Oxycodone/ Acetaminophen) 5-325 milligrams (mg) at each administration totaling four tablets each of the two shifts. On 11/02/22 at 8:27 A.M. interview with LPN #112 revealed the incident involving Resident #86 happened about three weeks ago. The resident told her the morning of 10/12/22 (the day before the incident was reported to administration) he did not get his pain medication from the night shift nurse (RN #125) as he requested and the resident suspected the nurse gave him something else instead. The LPN stated she showed the resident what his PRN Percocet looked like after he questioned whether he was being given the correct medication. The next morning (10/13/22) when she came to work, the resident asked to see her. The resident had four stool softeners to show her that he stated had been given to him by RN #125 after he had requested his Percocet pain medication. LPN #112 verified what the resident was given was Colace and not his PRN Percocet. She denied the resident had an order to receive Colace. The LPN revealed the night before (10/11/22- 10/12/22), the resident reported he was up all night with pain and had to go to the bathroom to defecate. She stated the PRN Percocet was ordered on a PRN basis and the resident would have to ask for it before it being administered. The LPN revealed the resident was given two Colace 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 were not the same that he had received previously. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/02/22 at 5:38 P.M. interview with the facility's Administrator and Director of Nursing (DON) revealed they both were involved in the investigation of SRI tracking number 228015 and RN #125's alleged misappropriation of Resident #86's PRN Percocet. Resident #86 thought things did not seem right with his medications. LPN #112 was the first to hear about the resident's concerns (on 10/11/22), but stated she did not have immediate concerns when it was first brought to her attention. The Administrator and DON were aware LPN #112 showed the resident what his Percocet looked like so in the event he thought something was wrong, he would know. On the evening of 10/12/22 going into 10/13/22, the resident reported he requested pain mediation and RN #125 brought medication into him that didn't look right. He placed the medication to the side after not taking them. Later that morning, RN #125 came in again with his PRN pain medication and he informed her they did not look right. RN #125 looked at them then gave them back to him telling him they came in a new box. The resident placed the medication under his tongue and removed them after she left the room. LPN #112 came in around 7:00 A.M. that morning as the day shift nurse. He showed LPN #112 the medication that was given to him by RN #125 as his PRN pain medication. LPN #112 verified the PRN pain medication was not his Percocet but was Colace instead. The Administrator confirmed four capsules of Colace were shown to LPN #112 that morning. It was after this second night that LPN #112 reported the incident to the Administrator. Witness statements were obtained and a SRI was initiated. The facility suspended RN #125 pending an investigation. The Administrator revealed although the suspected RN #125 took the PRN Percocet, they did not feel they could prove it. The Administrator revealed as part of the facility investigation the they looked at other resident's narcotic documentation to see if a pattern was seen with PRN pain medications. The Administrator revealed it seemed odd to him Resident #86 may have used his PRN pain medications here and there for other nurses but when RN #125 worked she seemed to administer it to the resident more frequently. They calculated about 46% of Resident #86's pain medication ordered on a PRN basis was given by RN #125. They suspected concerns with other residents controlled narcotic pain medications during their facility wide investigation as well. The Administrator indicated, because of their investigation into Resident #86's misappropriation, the facility unsubstantiated as their evidence was inconclusive. They suspected RN #125 took the PRN Percocet, but did not feel they could prove it. Their policy on medication diversion did not permit them to drug test staff suspected of medication diversion without evidence of the employee showing signs of being under the influence. He believed the local police investigation hit a dead end as well due to RN #125 refusing to take a polygraph test. He denied Resident #86 was reimbursed for the PRN Percocet that was signed out for him, but not administered. He acknowledged the four doses could not be accounted for, since they were signed out and it was proven what was given to the resident for those documented doses were not the PRN Percocet he should have been given. The DON confirmed there was no order for the resident to receive Colace on a scheduled or PRN basis. She stated that was what they used to be able to terminate the nurse, since she administered it without an order. The DON acknowledged RN #125 did not follow the physician's orders regarding the provided parameters in which the PRN Percocet could be given or at what dose. A review of the facility policy on Abuse, Neglect, and Exploitation revised 01/01/22 revealed it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The definition of misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Possible indicators of abuse included resident reports of theft of property. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident #110's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including the presence of a left artificial knee joint and aftercare following joint replacement surgery. A review of Resident #110's Minimum Data Set (MDS) 3.0 assessment, dated 10/13/22 revealed the resident did not have any communication issues as she was able to make herself understood and was able to understand others. The assessment revealed the resident was also noted to be cognitively intact and was not known to have displayed any behaviors. The resident was assessed to have complaints of frequent pain that she rated a 7 on a 1-10 scale at it's worst. The assessment revealed the pain did not affect her sleep or day to day activities. A review of Resident #110's care plans revealed a care plan, dated 10/05/22 related to being at risk for pain related to a recent left knee replacement. The goal was for the resident to verbalize adequate relief of pain or the ability to cope with incompletely relieved pain. Interventions included administering pain medication as ordered. A review of Resident #110's physician's orders revealed she had an order in place to receive Hydrocodone-Acetaminophen (Norco) 5- 325 mg by mouth every four hours as needed (PRN) for a pain level between 6-10 on a 1-10 scale. A review of Resident #110's Controlled Drug Receipt/ Record/ Disposition Form for her Norco (a narcotic pain medication used to treat moderate to severe pain) 5- 325 mg tablets revealed RN #125 documented she pulled a dose of Norco from the controlled medication supply on 10/12/22 at 1:44 A.M. and again at 5:52 A.M. A review of Resident #110's MAR for October 2022 revealed RN #125 only documented the resident was given a dose of Norco on 10/12/22 at 1:44 A.M. There was no documented evidence of the resident being given a dose of her PRN Norco on 10/12/22 at 5:52 A.M. as signed out on the Controlled Drug Receipt/ Record/ Disposition Form. A review of the facility's investigation pertaining to SRI tracking number 228015 revealed Resident #110 was reviewed as a like resident related to another resident's allegation of misappropriation of medications. The facility reviewed other residents narcotic pain medication count sheets as part of their investigation to include Resident #110's. The resident's Controlled Drug Receipt/ Record/ Disposition Form for her Norco (Hydrocodone- Acetaminophen) 5-325 mg tablets revealed a dose was noted to have been given to the resident on 10/12/22 at 5:52 A.M. by RN #125. The dose signed out on the Controlled Drug Receipt/ Record/ Disposition Form by RN #125 was not recorded on Resident #110's October 2022 MAR to show documented evidence the Norco had been actually administered to the resident. The facility's investigation included a written statement from the facility's Administrator revealing he had a conversation with LPN #112 who indicated she had spoken with Resident #110 about her PRN pain medication prior to the resident's discharge from the facility. LPN #112 reported Resident #110 told her there were many times she did not receive her PRN pain medication when reviewing what was documented as having been given on the Controlled Drug Receipt/ Record/ Disposition Form. The Administrator indicated in the same written statement he reached out to Resident #110 on two occasions but was unable to reach her as he did not receive a return call. Resident #110 was discharged from the facility on 10/13/22. (continued on next page)

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	365687	A. Building B. Wing	11/15/2022

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

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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 given 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 been signed out on the Controlled Drug Receipt/ Record/ Disposition Form but was struck out on the MAR. RN #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 on the 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 confirmed her investigation determined the Norco was signed out and marked on the MAR but had been struck out. It was no longer recorded to show it had been received. She stated their interview with RN #125 revealed she had wasted the Norco when it was not given to the resident. The nurse did not have another nurse witness 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 and was not documented as having been given on the MAR, the medication was misappropriated as it could not 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 account 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-compliance investigated under Complaint Number OH00136857, Control Number OH00136889 and Control Number OH00136939.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure Resident #28 received appropriate services to maintain range of motion/mobility and failed to ensure Resident #38 received restorative services. This affected two residents (#28 and #38) of five residents reviewed for position/range of motion and mobility. Findings include: 1. Medical record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including unspecified fracture of shaft of left humerus, hypertension, atrial fibrillation, and muscle weakness. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/06/22 revealed a Brief Interview for Mental Status (BIMS) score of 13 (out of 15), which indicated intact cognition. The assessment revealed the resident had no behaviors or rejection of care. The MDS further revealed Resident #28 required extensive, two-person assistance with personal hygiene, bed mobility, and transfers. The MDS assessment revealed the resident did not receive restorative nursing services or splinting. Review of the care plan, dated 10/19/22 revealed Resident #28 would be able to improve functionality to arm with an intervention for an elastic wrist brace, to right wrist, as tolerated. Review of the physician's orders revealed an order, dated 10/18/22 for an elastic wrist brace to the right wrist for stabilization of the wrist, every shift. On 10/31/22 at 2:26 P.M., Resident #28 was observed without the elastic wrist brace in place. During observation on 11/01/22 at 2:54 P.M., Resident #28 was lying in bed and not wearing an elastic wrist brace as ordered. During interview on 11/01/22 at 2:57 P.M., State tested Nursing Assistant (STNA) #51 confirmed Resident #28 was not wearing his right wrist elastic brace. STNA #51 stated she did not know there was an order for a wrist brace. During interview on 11/01/22 at 2:58 P.M., Licensed Practical Nurse (LPN) #112 revealed she was unaware of Resident #28 having the order for a wrist brace and she had not observed him to be wearing one during the past week or so. During interview on 11/01/22 at 3:00 P.M., Occupational Therapist (OT) #144 stated the wrist brace arrived last week and she personally gave the brace to Resident #28's nurse to apply to the resident's wrist. During interview on 11/01/22 at 3:30 P.M., the Director of Nursing (DON) confirmed Resident #28 was not wearing the right wrist brace as ordered. The DON verified the wrist brace had been found in the resident's room and applied per physician order. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45440 2. Review of Resident #38's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypercapnia, hereditary spastic paraplegia, essential hypertension and generalized muscle weakness. Review of admission MDS 3.0 assessment, dated 08/25/22 revealed Resident #38 was cognitively intact and required extensive assistance from two staff for bed mobility, dressing and toileting and total dependence from two staff to assist for transfers and locomotion on and off the unit. The MDS also revealed Resident #38 was receiving speech therapy, occupational therapy and physical therapy and not receiving any restorative nursing. Review of Resident #38's physician's orders revealed an order, dated 09/26/22 for restorative therapy by nursing. Review of Resident #38's care plan, dated 10/12/22 revealed the resident was to have active (motion at a joint when the resident moves the joint voluntarily) range of motion (ROM). The care plan revealed Resident #38 would benefit from a restorative active ROM for impaired physical mobility of upper extremities (arms) and lower extremities (legs) of both sides (bilateral). Review of the documentation for restorative nursing revealed Resident #38 was to receive level two restorative nursing for active ROM. Resident #38 was to tolerate 15 minutes of active ROM to bilateral upper and lower extremities daily to maintain joint motion. This documentation also revealed Resident #38 received restorative active ROM on 10/24/22, 10/25/22, 10/29/22, 10/30/22, 11/05/22 and 11/06/22. Based on the date of the order, Resident #38 received restorative active ROM only six days out of 41 potential days. On 10/31/22 at 11:39 A.M. interview with Resident #38 revealed staff were not doing anything for her limited ROM. She reported she had only been guided with active ROM a few times. The resident felt she had experienced some decrease in her ROM. On 11/03/22 at 8:15 A.M. during a follow up interview Resident #38 revealed no staff had worked with her to assist with ROM exercises. On 11/07/22 at 8:23 A.M. interview with Registered Nurse (RN) #90 revealed she did not know if Resident #38 received restorative nursing services. After RN #90 reviewed Resident #38's orders, RN #90 verbalized Resident #38 was to receive therapy, but wasn't sure about restorative nursing services. On 11/07/22 at 8:24 A.M. interview with RN #41 revealed Resident #38 was to receive active ROM to her upper and lower extremities. RN #41 reported Resident #38 had been receiving restorative nursing services since 09/30/22 and RN #41 was not sure why it took four days to initiate the restorative nursing order. She reported according to the order, the restorative therapy should have been started earlier. RN #41 reported there was only one restorative aide (RA), and when RA #111 wasn't working, the floor aides did not pick up the restorative nursing duties. On 11/07/22 at 8:35 A.M. interview with the DON revealed RA #111 had been off since 10/05/22 and there were no other staff performing the restorative services for residents, including Resident #38. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. This deficiency represents non-compliance investigated under Complaint Number OH00137086.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on observation, record review, review of facility fall investigations, facility policy and procedure review 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: 1. 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 stroke and having the inability to ambulate. Interventions included anticipating/ meeting the resident's needs based on nursing assessments. A review of Resident #92's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/06/22 revealed the resident did not have any communication issues and her cognition was moderately impaired. The assessment revealed the resident's vision was adequate with the use of corrective lenses. She was not known to have any behaviors and was not known to reject care. The assessment revealed the resident required extensive assistance from two staff for transfers and toilet use and ambulation did not occur. Balance issues were noted when going from a seated to a standing position and with surface to surface transfers requiring physical help from staff to stabilize. The resident exhibited functional limitation in her range of motion to the upper and lower extremity on one side. The resident was not indicated to have had 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 resident was assisted to the floor by staff. The note indicated a State tested Nursing Assistant (STNA) was helping the resident transfer into bed when the resident started sliding. The STNA assisted the resident to the floor. 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	A review of a fall investigation for Resident #92's fall on 05/08/22 revealed the fall was as indicated in the progress note. The resident was indicated to have been assisted to the floor by staff. Mitigating factors was the resident was not wearing proper footwear and the intervention added was to ensure the resident was wearing proper footwear when transferring to the bed or chair. The fall occurred at 10:15 P.M. and occurred in the resident's room. STNA #500 was identified as the staff member who transferred the resident at the time of her fall. A subsequent quarterly MDS 3.0 assessment, dated 07/01/22 revealed the resident remained an extensive assist of two staff for transfers. The assessment noted the resident had one fall with injury that was not major injury. On 11/03/22 at 1:31 P.M., an interview with STNA #500 revealed she worked the night of 05/08/22 when Resident #92 had to be lowered to the floor during a transfer. She confirmed she was the STNA who was assisting the resident with during the transfer. She was able to recall the incident as she stated she pulled her hamstring as a result of that incident. She reported she was transferring the resident from her wheelchair to her bed. She denied she had another STNA or staff member assisting with the transfer. The STNA revealed when she stood the resident up, the resident's feet started to slide so she lowered the resident to the floor. She was questioned on the assistance level the resident required for transfers at the time the incident occurred. The STNA stated as far as she knew, the resident only required a one person assist. She was not sure how it was communicated to the STNA staff the assistance level a particular resident needed with transfers. She went by what she was told by the nurse and a nurse had told her the resident was to be a one person assist with transfers. She could not recall which nurse told her that. She denied the resident had proper footwear on at the time of the transfer, as she was wearing regular socks. The STNA failed to ensure the resident had proper footwear on when transferring her from the wheelchair into bed. She confirmed she was the only STNA on the floor at the time as her coworker was on break. A nurse was available on the unit that she could have asked for assistance if needed. She denied she asked the nurse to assist with the resident's transfer as the nurse was busy. On 11/03/22 at 1:49 P.M., an interview with Director of Nursing (DON) revealed Resident #92 did have a fall on 05/08/22 that was a result of her not having proper footwear on at the time of the fall. She confirmed the resident's transfer on 05/08/22 was performed by one STNA, when the resident's prior MDS assessment identified her as requiring a two person assist with transfers. The DON acknowledged the fall on 05/08/22 could not be considered an unavoidable fall due to her not having proper footwear on while being transferred by staff and not having the appropriate assistance level when being transferred from her chair to bed. A review of the facility policy on Fall Prevention Program, revised 01/01/22 revealed each resident would be assessed for the risk of falling and would receive care and services in accordance with the level of risk to minimize the likelihood of falls. The policy included the definition of a fall to include a near miss which was also considered a fall. A near miss was when a resident would have fallen if someone else had not caught the resident from doing so. The facility would use a standardized risk assessment for determining a resident's fall risk. Each resident's risk factors and environmental hazards would be evaluated when developing the resident's comprehensive plan of care. 32801 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnosis including diffuse traumatic brain injury with loss of consciousness, hemiplegia and hemiparesis, aphasia, apraxia, lupus anticoagulant, and cognitive communication deficit. Record review revealed a plan of care, (initiated 08/17/20) related to the resident's history of falls and traumatic brain injury. Interventions included (on 07/21/22 and revised 10/10/22) to ensure chair and bed alarms were functioning and in place and (09/08/22) ensure mattress was securely fastened to bed frame. Record review revealed a fall investigation, dated 07/20/22 indicating Resident #41 was found on the floor by an STNA. The resident appeared to have slid out of bed onto his buttocks. The investigation revealed the resident's bed alarm was not in place and was found underneath the resident's Dycem in the chair. Returned alarm to bed and placed a new alarm on electric chair. There was no evidence the facility determined a root cause of the fall. Staff were educated on the placement of alarms and function. Review of Resident #41's fall risk evaluations revealed there was no evidence a new fall risk evaluation was completed after the fall that occurred on 07/20/22. Review of Resident #41's Minimum Date Set (MDS) 3.0 assessment, dated 09/02/22 revealed the resident required extensive assistance from two for dressing and bed mobility and was totally dependent on staff for transfers. Review of Resident #41's fall investigation, dated 09/19/22 revealed the resident was lying on the mat next to his bed. The resident had turned himself around in the bed so that his head was at the bottom. There was no evidence the facility investigation determined a root cause of the fall. Review of Resident #41's fall risk evaluations revealed there was no evidence a new fall risk evaluation was completed after the fall that occurred on 09/19/22. Review of Resident #41's fall investigation, dated 10/04/22 revealed the resident was found crawling on the floor from his room out into the hallway. There was no evidence the facility determined a root cause of the fall. Further review revealed on 10/04/22 the resident was noted to be high risk for falls because he had three or more falls in the last 90 days. The resident displayed no behaviors, required assistance with elimination, was confined to chair, and not able to attempt to balance without physical assistance. Under health conditions and risk staff did not check neuromuscular/functional for loss of arms or leg movement. On 11/01/22 at 2:40 P.M. observation of Resident #41 with an unidentified STNA revealed interventions were in place except for chair and bed alarms. The resident was in bed at the time of the observation and the surveyor was unable to check the mattress to ensure it was secure. On 11/02/22 at 8:20 A.M. observation with STNA #46 verified the resident had no bed or chair alarm. The STNA reported all alarms had been discontinued recently for all residents, including Resident #41. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/22 at 11:11 A.M. observation of Resident #41 with STNA #16 and Unit Manager (UN) #65 revealed the resident's mattress was not strapped/secured to the bed. Staff reported it was a new mattress and that the intervention to secure the mattress to the bed frame should probably have been removed from the plan of care. The staff members revealed the resident was not able to physically roll by himself, however he could scoot his body. On 11/01/22 at 3:03 P.M. interview with Resident #41's mother revealed she had concerns that her son had fallen out of bed four times even though he was unable to move much. The resident's mother felt there was no reason the resident should be falling out of bed. On 11/08/22 at 9:32 A.M. and 10:05 A.M. interview with the Director of Nursing (DON) verified Resident #41's falls on 07/20/22, 09/19/22 and 10/04/22 were not thoroughly investigated to determine the root cause nor were fall risk assessments completed after the falls that occurred on 07/20/22 and 09/19/22. The DON reported a new fall risk assessment were supposed to be completed after each fall. The DON confirmed the resident's plan of care had not been revised on 10/11/22 when the alarms were discontinued or when the mattress was replaced with a new one and no longer required to be secured to the bed frame. Review of facility Accidents and Supervision policy, dated 10/30/20 and revised 08/11/22 revealed each resident would be reassessed for fall risk and would receive care and services in accordance with their individual level of risk to minimize the likelihood of falls. Review of the Fall Prevention Program policy, dated 10/20/20 and revised 01/01/22 revealed each resident would be assessed for the risk of falling and would receive care and services in accordance with the level of risk to minimize the likelihood of falls. Each residents risk factors, and environmental hazards would be evaluated when developing the residents comprehensive plan of care. Interventions would be monitored for effectiveness and the plan of care would be revised as needed. When any residents experienced a fall, the facility would assess the resident, complete a post-fall assessment, complete and incident report, notify physician and family, review the resident's plan of care, and update as indicted, document all assessments and actions, obtain witness statements in the case of injury. This deficiency represents non-compliance investigated under Complaint Number OH00133600.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 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 misappropriation 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 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 Percocet (a controlled narcotic pain medication used in the treatment of moderate to severe pain) 5- 325 mg tablets with directions to give one tablet by mouth every six hours PRN for pain rated a three to six on a 1-10 scale. The instructions indicated two tablets could be given for pain levels between a seven and 10 on a 1-10 scale. (continued on next page)

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	365687	A. Building B. Wing	11/15/2022

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #86's medication administration record (MAR) for October 2022 revealed RN #125 documented administering the resident his PRN Percocet twice during her night shift going from the evening of 10/11/22 into the morning of 10/12/22 and again the evening of 10/12/22 going into the morning of 10/13/22. During all four administrations of the PRN Percocet, RN #125 documented she gave the resident 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. Upon further investigation, it was confirmed the pills Resident #86 received were actual stool softener, Colace 100 mg capsules and not his PRN Percocet ordered for pain. The information was brought to the Administrator's attention and an investigation began with RN #125 being suspended pending the outcome of the investigation. Resident #86's physician's orders were reviewed as part of the facility's investigation, and it was determined the resident did not have a physician's order to receive Colace 100 mg capsules on a scheduled or a PRN basis. Statements were obtained from Resident #86 and LPN #112 as part of the facility's investigation. The local police department were also informed of the alleged misappropriation of controlled narcotic pain medication. The facility unsubstantiated the allegation of misappropriation at the conclusion of their investigation indicating the evidence was inconclusive, although misappropriation was suspected. RN #125 was terminated from employment but was terminated due to nursing policies in regard to medication and documentation being violated. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's investigation revealed a witness statement from Resident #86 was obtained. The resident reported in his statement the night before (10/11/22- 10/12/22) the nurse (RN #125) gave him pills for pain and he did not get any relief from his pain after taking the pills nor did they make him sleep. He informed another nurse about it (LPN #112) and she encouraged him to check his pills the next time they were given to him and told him what to look for. The resident alleged he had received four pills that were not the same pain pills he was familiar with receiving. The evening of 10/12/22 going into the morning of 10/13/22, the resident indicated he informed the nurse (RN #125) the pills she was giving him did not look right. The nurse took them back, looked at them, and handed them back to him while telling him they had come from a new box. He had to put them in his mouth under his tongue until she left and then he took them out of his mouth. A witness statement from LPN #112 confirmed Resident #86 had reported to her the morning of 10/12/22 that he did not know what the night shift nurse (RN #125) had given him, but that it was not his pain pills. Resident #86 informed LPN #112 he was in pain all night (10/11/22- 10/12/22) and could not sleep. He also reported to her that he was using the bathroom all night to defecate. She offered for him to file a complaint then, but the resident declined. The resident remained adamant he did not receive the proper pain medication. LPN #112 stated she told the resident to look at his pills the next time and if they did not have the identifying numbers on them as his PRN Percocet did then they were not his pills. The nurse hoped that would clear things up and prove he was getting the proper medication. She stated, however, it did not. The resident kept his pills he was given the next night (10/12/22) as his PRN pain medication and showed her the morning of 10/13/22. The nurse indicated in her witness statement that what was given to the resident were stool softeners. At that time, the resident requested to file a complaint. A review of an email from RN #125 to the facility's Administrator, sent 10/20/22 at 10:36 A.M. revealed, on her shift from the evening of 10/12/22 to the morning of 10/13/22, she woke Resident #86 that morning to give him his pain medication. She also gave the resident stool softeners as he had told her earlier he had not gone to the bathroom, so she gave him two stool softeners after his pain medication. The facility's investigation file also included a complaint form to the State of Ohio Board of Nursing, dated 10/27/22 that revealed the facility's Director of Nursing (DON) filed a complaint with the Board of Nursing about RN #125. A description of the complaint or violation revealed RN #125 had been suspended for misappropriation. Their investigation revealed violations of three company policies that resulted in her termination from employment. The involved resident was mentioned in the complaint and the resident was indicated to have had pain management issues related to the practice breakdown. The resident was indicated to have received the wrong medication and reported he did not receive the pain medication that was signed off as having been administered to him. The DON indicated no harm occurred to the resident despite him having unrelieved pain that kept him up all night. The involved nurse was also indicated to have administered a medication (Colace) without a physician's order to do so. The DON added the resident reported he was given the wrong medication when he asked for his PRN pain medication. Their investigation revealed the nurse gave Colace to the resident without an order, inappropriate documentation related to signing the medication administration record (MAR's) at the correct times, and improper waste of a narcotic medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of a Controlled Drug Receipt/ Record/ Disposition form for Resident #86's Percocet that was included in the facility's investigation file revealed RN #125 documented she gave the resident his PRN Percocet twice on the evening of 10/11/22 going into the morning hours of 10/12/22 and again the evening of 10/12/22 going into the morning hours of 10/13/22. Both times she signed to reflect she gave the resident two tablets of Percocet (Oxycodone/ Acetaminophen) 5-325 milligrams (mg) at each administration totaling four tablets each of the two shifts. On 11/02/22 at 8:27 A.M. interview with LPN #112 revealed the incident involving Resident #86 happened about three weeks ago. The resident told her the morning of 10/12/22 (the day before the incident was reported to administration) he did not get his pain medication from the night shift nurse (RN #125) as he requested and the resident suspected the nurse gave him something else instead. The LPN stated she showed the resident what his PRN Percocet looked like after he questioned whether he was being given the correct medication. The next morning (10/13/22) when she came to work, the resident asked to see her. The resident had four stool softeners to show her that he stated had been given to him by RN #125 after he had requested his Percocet pain medication. LPN #112 verified what the resident was given was Colace and not his PRN Percocet. She denied the resident had an order to receive Colace. The LPN revealed the night before (10/11/22- 10/12/22), the resident reported he was up all night with pain and had to go to the bathroom to defecate. She stated the PRN Percocet was ordered on a PRN basis and the resident would have to ask for it before it being administered. The LPN revealed the resident was given two Colace 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 were not the same that he had received previously. On 11/02/22 at 5:38 P.M. interview with the facility Administrator and Director of Nursing (DON) revealed they both were involved in the investigation of SRI tracking number 228015 and RN #125's alleged misappropriation of Resident #86's PRN Percocet. Resident #86 thought things did not seem right with his medications. LPN #112 was the first to hear about the resident's concerns (on 10/11/22), but stated she did not have immediate concerns when it was first brought to her attention. The Administrator and DON were aware LPN #112 showed the resident what his Percocet looked like so in the event he thought something was wrong, he would know. On the evening of 10/12/22 going into 10/13/22, the resident reported he requested pain mediation and RN #125 brought medication into him that didn't look right. He placed the medication to the side after not taking them. Later that morning, RN #125 came in again with his PRN pain medication and he informed her they did not look right. RN #125 looked at them then gave them back to him telling him they came in a new box. The resident placed the medication under his tongue and removed them after she left the room. LPN #112 came in around 7:00 A.M. that morning as the day shift nurse. He showed LPN #112 the medication that was given to him by RN #125 as his PRN pain medication. LPN #112 verified the PRN pain medication was not his Percocet but was Colace instead. The Administrator confirmed four capsules of Colace were shown to LPN #112 that morning. It was after this second night that LPN #112 reported the incident to the Administrator. Witness statements were obtained and a SRI was initiated. The facility suspended RN #125 pending an investigation. The Administrator revealed although the suspected RN #125 took the PRN Percocet, they did not feel they could prove it. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00136857, Control Number OH00136889 and Control Number OH00136939.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, facility self-reported incident review and related investigation, facility policy and procedure review, review of Controlled Drug Receipt/ Record/Disposition Forms, review of narcotic shift count sheets and interview the facility failed to ensure routine medications were provided to residents as ordered and failed to provide adequate pharmaceutical services to meet the needs of each resident. The facility failed to ensure controlled narcotic pain medication was timely/appropriately documented when administered to residents and proper shift to shift reconciliation counts of controlled medication were completed to identify any discrepancies in the counts. The facility also failed to ensure medications were available for administration from their contracted pharmacy. This affected three residents (#86, #102 and #110) of three residents reviewed for misappropriation of medication and one resident (#2) of five residents reviewed for unnecessary medication use. Findings include: 1. A review of Resident #86's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including a left hip fracture, the presence of a right and left artificial hip joint, and low back pain. A review of Resident #86's physician's orders revealed the resident had an order in place to receive Percocet (a narcotic pain medication used in the treatment of moderate to severe pain) 5- 325 milligrams (mg) by mouth every six hours as needed (PRN) for pain. The order included parameters in which to give one tablet or two based on the resident's pain level. The resident was to receive one tablet for a pain level between three and six on a 1-20 scale and two tablets for a pain level between seven and 10. A review of Resident #86's Controlled Drug Receipt/ Record/ Disposition Form for his Percocet 5- 325 mg tablets revealed the resident was provided 60 tablets of Percocet 5- 325 mg on 10/07/22 from the facility's contracted pharmacy. The receipt of the controlled narcotic pain medication was signed by the pharmacist but was not signed by the nurse who received it upon delivery from the pharmacy. It was also not witnessed by another nurse to confirm 60 tablets of the Percocet 5- 325 mg had been received on 10/07/22. The nurses started signing out doses from that supply beginning 10/07/22 at 1:00 P.M. A review of the narcotic shift count sheet for A/B Hall (where Resident #86 resided when he was in the facility) revealed the off going nurse and the on coming nurse did not consistently document they compared the controlled medication cards on hand with the controlled medication count sheets to identify any discrepancies between the two which could indicate medication diversion/ misappropriation. The narcotic count sheets with missing documentation was for the time period between 10/09/22 and 10/13/22. Findings were verified by the DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility self-reported incident (SRI) tracking number, 228015 revealed an allegation of misappropriation was made on 10/13/22 by Resident #86. The resident was the initial source of the allegation and a facility staff member was indicated to be the alleged victim. Resident #86 was noted to have been able to provide meaningful information when interviewed and the date/ time/ occurrence of the alleged incident was 10/13/22 at 5:40 A.M. in the resident's room. Resident #86 alleged he was given something other than his ordered as needed (PRN) pain medication (Percocet) for complaints of pain by Registered Nurse (RN) #125. As part of the facility's investigation, narcotic sheets were reviewed for the resident and other like residents. As a result of the facility's investigation, it was determined nursing policies in regard to medication and documentation were violated. The involved nurse (RN #125) was terminated from employment. A review of RN #125's employee personnel file revealed it contained a Performance Improvement Form, dated 10/20/22 that indicated counseling/corrective actions were taken against the nurse for standards of conduct. The employee was indicated to have violated company policy related to documentation not taking place at the time medication was being administered. The employee was also indicated to have violated company policy related to the improper wasting of a controlled narcotic involving another resident that was found by the DON during the course of the investigation. The employee had been discharged from employment as a result of those violations. A review of a complaint form to the State of Ohio Board of Nursing, dated 10/27/22 revealed RN #125 had been reported to the Board of Nursing by the facility's Director of Nursing (DON). The complaint form was part of the facility's investigation file for the allegation of misappropriation of Resident #86's medication in SRI number 228015. RN #125 was indicated to have been suspended pending an investigation into allegations of misappropriation. The investigation identified concerns with improper documentation related to the signing of MAR's at the correct times and the improper wasting of a narcotic. RN #125 was terminated based on three violations of company policy. On 11/02/22 at 5:38 P.M., an interview with the facility DON revealed she was involved in the facility's investigation of SRI tracking number 228015. She confirmed the facility identified concerns with controlled medication documentation; when they were used, the reconciliation of controlled medications between shifts and not having two nurses sign controlled medication receipts when the controlled medication was delivered from the pharmacy. She stated two nurses should be signing off that a controlled medication had been received from the pharmacy. She confirmed there was no documentation to show two nurses had signed receipt of Resident #86's Percocet when it was delivered on 10/07/22. She also reported the off going nurse and on coming nurse should be recording the number of controlled medication cards that were in the medication administration cart with the sheets for those controlled medications as a means to ensure medication diversion/ misappropriation did not occur. She indicated, by recording the cards to sheet count, it verified that the two nurses were actually counting the controlled medication to ensure the doses they had on hand was the same as the remaining count on the count sheets. If the amount of the controlled medication on hand did not match with the amount remaining on the sheet balance, the nurses were to determine what happened and to account for the discrepancy noted. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy on Controlled Substance Administration and Accountability policy, revised 01/01/22 revealed it was the policy of the facility to promote safe, high quality patient care, compliant with State and federal regulations regarding monitoring the use of controlled substances. The facility would have safeguards in place in order to prevent loss, diversion or accidental exposure. Controlled medications must be counted upon delivery. The nurse receiving the delivery, along with the person delivering the medication, must count the controlled substance together. Both individuals must sign the designated narcotic record. When a resident refused controlled medications or it was not given, the medication shall be destroyed. All destructions must be conducted in the presence of two licensed nurses or a pharmacist. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. Documentation should be made on the shift verification sheet. 2. A review of Resident #110's closed medical record revealed revealed the resident was admitted to the facility on [DATE] with diagnoses including the presence of a left artificial knee joint, aftercare following joint replacement surgery, and osteoarthritis of the right knee. A review of Resident #110's physician's orders revealed an order, dated 10/11/22 for Hydrocodone-Acetaminophen (Norco) 5- 325 mg by mouth every four hours as needed (PRN) for pain rated between six and 10 on a 1-10 scale. A review of Resident #110's Controlled Drug Receipt/ Record/ Disposition Form revealed a dose of the Norco 5-325 mg was signed out by RN #125 on 10/12/22 at 5:52 A.M. A review of Resident #110's medication administration record (MAR) for October 2022 revealed RN #125 did not document a dose of Norco was given on 10/12/22 at 5:52 A.M. as was indicated on the Controlled Drug Receipt/ Record/ Disposition Form. She did document a dose was given on 10/12/22 at 1:44 A.M. but no additional doses was indicated as having been given by the nurse that night. A review of RN #125's employee personnel file revealed she received counseling/ corrective action on 10/20/22 for violating company policy related to the improper wasting of narcotics. It was indicated to have been found by the facility's DON during the course of the facility's investigation into SRI #228015 pertaining to the misappropriation of medication. On 11/02/22 at 2:50 P.M., an interview with the DON revealed RN #125 was found to have improperly wasted a narcotic pain medication for Resident #110, when she was investigating another resident's allegation of misappropriation of his controlled narcotic pain medication. She stated the facility determined RN #125 had wasted a dose of Norco ordered for Resident #110 that was ordered on an as needed (PRN) basis. She stated the nurse signed the dose of Norco out on the Controlled Drug Receipt/ Record/ Disposition Form but had struck the dose out on the MAR. She reported the nurse told her she wasted the dose but did not have the destruction of the controlled medication witnessed by another nurse. RN #125's employment at the facility was terminated as a result of violating company policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of SRI tracking number 218831 revealed an allegation of misappropriation was made by Resident #102 on 03/09/22. Resident #102 was the initial source of the allegation and a facility staff member was indicated to be the alleged perpetrator. Resident #102 was able to provide meaningful information when interviewed. The date and time of the occurrence was 03/09/22 at 6:30 P.M. The resident alleged he was not given his scheduled doses of Methadone (a narcotic used to treat moderate to severe pain or could also be used to treat narcotic drug addiction) that was to be given at 12:00 P.M. or his Adderall (a stimulant used in the treatment of attention deficit hyperactivity disorder or narcolepsy) that was to be given at 2:00 P.M. The nurse alleged as having misappropriated the resident's medication was LPN #510. A witness statement from LPN #510 (that was obtained as part of the facility's investigation for SRI tracking number 218831) obtained via phone revealed the nurse was asked by the DON if she gave Resident #110 the medication he (the resident) alleged to not have received. The nurse reported she gave the Methadone and Adderall at 1:13 P.M. A review of Resident #102's MAR for March 2022 revealed LPN #510 did sign the MAR to reflect she had administered the resident his scheduled dose of Methadone 10 mg as ordered three times a day at 12:00 P. M. She also signed the MAR to reflect she had given him his scheduled dose of Adderall 20 mg tablet as ordered twice a day at 2:00 P.M. A review of Resident #102's Controlled Drug Receipt/ Record/ Disposition Forms for his Methadone 10 mg tablets and Adderall 20 mg tablets revealed LPN #510 signed out his dose of Methadone and Adderall on 03/09/22 at 1:13 P.M. A review of a Medication Administration Audit Report for Resident #102 revealed the report showed when those two medications had been administered to the resident on 03/09/22. The resident was indicated to have been given his Methadone by LPN #510 at 11:12 A.M. despite the Controlled Drug Receipt/ Record/ Disposition Form showing the controlled medication was not signed out until 1:13 P.M. The medication audit report documented the administration of the Methadone as being 1:13 P.M. The administration audit report showed the Adderall 20 mg tablet had been administered at 1:12 P.M. by LPN #510 on 03/09/22. She documented the administration of the Adderall on the MAR at 1:13 P.M., which was consistent with what was documented on the Controlled Drug Receipt/ Record/ Disposition Form. On 11/08/22 at 2:50 P.M., an interview with the DON revealed the facility believed Resident #102 received his medications (Methadone and Adderall) as scheduled on 03/09/22, but thought LPN #510 just did not complete her documentation on the MAR or on the Controlled Drug Receipt/ Record/ Disposition Form until later that day when the scheduled Adderall was given. She stated the nurse should be documenting the administration of a controlled medication on the MAR at the time the medication was actually administered and should also sign it out on the Controlled Drug Receipt/ Record/ Disposition Form at the time of administration. 32801 4. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, anxiety, and depression. (continued on next page)

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Arbors at Marietta	400 Seventh Street Marietta, OH 45750

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Further review of MAR revealed the resident did not receive the Lamictal on 10/29/22, 10/30/22 or 10/31/22 as it was not available from pharmacy. Review of Resident #2's progress notes revealed the resident's physician was not notified the medication was not available or administered until 11/01/22. On 11/07/22 at 1:55 P.M., interview with the Director of Nursing (DON) revealed the pharmacy had the order entered incorrectly as 25 mg, one tablet at bedtime instead of two tablets at bedtime. The DON reported the pharmacy system was kicking out the orders and the pharmacy was having to re-enter them; however, it didn't affect the facilities orders. The DON confirmed the physician was not notified until 11/01/22 the resident did not receive the medication on 10/29/22. 10/30/22 or 10/31/22. The DON reported she would need to do a medication error report and do immediate staff education regarding the incident. This deficiency is an example of non-compliance investigated under Control Number OH00136939 and Control Number OH00136889.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365687	A. Building B. Wing	11/15/2022

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

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 45440 Based on observation, facility policy and procedure review and interview the facility failed to ensure pureed food was prepared to the correct consistency. This had the potential to affect 10 residents (#1, #33, #51, #59, #62, #71, #73, #76, #106 and #310) of ten residents who received pureed diets. The facility census was 100. Findings include: On 11/01/22 at 9:00 A.M. Dietary Aide (DA) #157 was observed completing the pureed meal process. DA #157 pureed pork using all of the juices the pork was in and after tasting it reported the pork was ready to serve. This surveyor then tasted the pork, however, it was not the appropriate pureed texture and needed to be chewed. DA #157 then verified it did need to be chewed and was not the correct puree consistency. DA #157 then continued to pureed the pork again with four tablespoons of thickener and then again with three more tablespoons of thickener to achieve the correct puree consistency. DA #157 continued the process and pureed potatoes and after tasting it reported the potatoes were ready to serve. This surveyor then tasted the potatoes, however, they were not the appropriate pureed texture and had chunks of potato in it. The Dietary Manager (DM) then tasted the potatoes and verified there were potato chunks in the puree, and it was not the correct pureed consistency. DA #157 then pureed the potatoes again to achieve the correct puree consistency. The facility indicated 10 residents, Resident #1, #33, #51, #59, #62, #71, #73, #76, #106 and #310 who received pureed diets. Review of the facility policy titled Therapeutic Diet Orders, reviewed/revised 01/01/22, revealed the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physicians, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45440 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. Review of the facility policy titled, Call Lights: Accessibility and Timely Response, reviewed/revised 01/01/22 revealed the purpose of the policy was to ensure the facility was adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance.