Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2023
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few			

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2023	
NAME OF PROVIDED OR SURDIUS		STREET ADDRESS CITY STATE 71	D CODE	
NAME OF PROVIDER OR SUPPLIE	=R	STREET ADDRESS, CITY, STATE, ZIP CODE		
Arbors at Marietta	Arbors at Marietta		400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0600	Review of a social services progres	ss note, dated 12/30/22 at 10:26 A.M.,	revealed Resident #1 was	
	interviewed after a report of peer-to	p-peer contact. The resident had a Brie	f Interview for Mental Status (BIMS)	
Level of Harm - Actual harm		The note revealed the resident had no in the staff or the resident. The resident		
Residents Affected - Few	distress, or depression reported by the staff or the resident. The resident did not recall the occurrence and staff stated the resident did not appear to understand or be bothered when the incident occurred. When asked if she felt safe in the facility, the resident began reciting illogical and irrelevant topics that were difficult to follow. The resident spoke of someone moving to a new location and asked if they had passed. The subject then changed to the resident going to the store for her arm.			
	Review of a nurse progress note, dated 12/30/22 at 11:02 A.M., revealed Resident #1 did not remember the incident and stated she felt safe in the environment. A skin check was completed. The resident denied pain, and the physician and responsible party were notified.			
	Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of cerebrum, traumatic subdural hemorrhage, aphasia, dementia, schizoaffective disorder, seizures, and muscle weakness. The resident was discharged from the facility on 01/09/23.			
	Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/21/22, revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, toileting, and personal hygiene. Review of the resident's behaviors revealed delusions, physical behaviors directed to others and other behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, screaming, and disruptive sounds. Review of Resident #2's physician order, dated 03/02/22, revealed the order to monitor behaviors, every shift, for urinating in inappropriate areas, tearfulness, delusions, taking other's drinks, hitting other residents, turning lights on and off, exposing self in hallway, wandering in and out of other's rooms, exiting, restlessness, being combative with staff, sleeplessness, pushing other residents in their wheelchairs, and for shutting other's doors.			
	#2 was involved in inappropriate re no increased anxiety or depression not recall the earlier incident. Staff was his grandmother. Staff reporte past 14 days which included standi	es note, dated 12/30/22 at 12:33 P.M., esident-to-resident contact. The resident reported. Resident #2 stated he felt sawere interviewed and reported the resid a significant increase in sexual behaving directly behind staff members and a resident was resistant to redirection withouted.	t's BIMS score was 3. There was afe in the facility. The resident could dent said he thought Resident #1 viors for Resident #2 during the attempting to grab their waists, but	
	were assessed for skin impairment made for Resident #2 to be dischar	dated 12/30/22, revealed all residents or injury and staff interviews were con rged to an all-male behavioral unit. The .M. and substantiated the allegation of	ducted. On 12/30/22, a referral was facility completed their	
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2023
NAME OF PROVIDER OR SUPPLIER Arbors at Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of State-tested Nurse Aide (STNA) #100's witness statement, dated 12/30/22, revealed STNA #100 came into the dining room and observed Resident #2 with his hand down the left side of Resident #1's shirt and rubbing her breast. STNA #100 asked Resident #2, why did you do this? Resident #2 stated, because she likes it. Review of Registered Nurse (RN) #105's witness statement, dated 12/30/22 at 6:50 A.M., revealed RN #105		
	was informed by STNA #100 of Re separated, Resident #1 was taken	sident #2 fondling Resident #1's left bro to her room and a skin sweep was con	east. The residents were ducted with no concerns.
	During interview on 01/11/23 at 10:48 A.M., the Director of Nursing (DON) confirmed the facility in did substantiate the allegation of sexual abuse between Resident #1 and Resident #2. During observation on 01/11/23 at 11:10 A.M., Resident #1 was sitting in her wheelchair, in the din of the memory care unit. The resident was smiling and holding a baby doll. The resident only smile not answer any questions. Resident #2 was discharged from the facility and was unable to be observed. Interview on 01/11/23 at 11:15 A.M., STNA #100 revealed she walked into the dining room of the recare unit and observed Resident #1 sitting in her wheelchair, in the middle of the room. Resident #1 standing behind Resident #1's wheelchair with his back toward the door. STNA #100 stated Resident hand was down Resident #1's wheelchair with his back toward the door. STNA #100 stated she asked Resident was doing, and he replied, nothing much, which was his usual response when asked a question of the stated, I was playing with her nipple because she likes it. STNA #100 revealed she asked Resident was, and he said Resident #1 was his grandmother. STNA #100 reveresidents were separated and she notified RN #105 of the incident. Resident #2 was placed on one observation. STNA #100 confirmed there was no staff member in the dining room at the time of the		
	this facility to provide protections for implementing written policies and proper warranted when suspicion of abuse Written procedures for investigation interviewing all involved persons, in might have knowledge of the allegativestigation. The facility will make psychosocial harm during and after immediately to protect the allegative any sign of injury, including a physicial process.	glect, and Misappropriation, dated 07/2 or the health, welfare, and rights of each procedures that prohibit and prevent abity. Investigation of Alleged Abuse: an it, neglect, or exploitation, or reports of an include identifying staff responsible facilitions; providing complete and thorough efforts to ensure all residents are protest the investigation. Examples include by victim and integrity of the investigation; cal examination or psychosocial assest diresidents; room or staffing changes, tor.	n resident by developing and use, neglect, exploitation, and mmediate investigation is abuse, neglect, or exploitation. For the investigation; identifying and petrator, witnesses, and others who in documentation of the exted from physical and ut are not limited to responding examining the alleged victim for sment if needed; increase
	, ,	npliance investigated under Master Cor OH00139364, and Self Reported Incid	•

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WANT OF BROWERS OF SUBBLE			
NAME OF PROVIDER OR SUPPLIE	ER .	STREET ADDRESS, CITY, STATE, ZIP CODE	
Arbors at Marietta		400 Seventh Street Marietta, OH 45750	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0602	Protect each resident from the wrongful use of the resident's belongings or money.		
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 33019
Residents Affected - Few	Based on record review, review of a facility self-reported incident (SRI), facility investigation, employee personnel file review, facility policy review, and interview, the facility failed to ensure residents were free from misappropriation of medications. This affected one (Resident #4) of three residents reviewed for misappropriation.		
	Findings include:		
	Review of the medical record for the Resident #4 revealed an admitted [DATE]. Diagnoses included schizophrenia, dementia, anxiety disorder, alcoholic cirrhosis of the liver, chronic kidney disease, and muscle weakness.		
	Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/28/22, revealed the resident had intact cognition. The resident required extensive assistance of two staff for transfers, and extensive assistance of one staff for toileting and personal hygiene. Review of the resident's behaviors revealed no psychosis or rejection of care.		
	Review of Resident #4's physician order, dated 12/21/22, revealed the order for Clindamycin HCL (antibiotic) capsule, give 450 milligrams (mg) three times per day, for seven days, for methicillin-resistant staphylococcus aureus (MRSA).		
	Review of the Self-Reported Incident (SRI) #230910, dated 01/09/23 at 5:47 P.M., revealed on 01/09/23 approximately 3:30 P.M., the Director of Nursing (DON) was notified by staff of a possible misappropriation of a discontinued medication belonging to Resident #4. The alleged nurse, Licensed Practical Nurse (LPN #115, was immediately suspended pending the investigation. Review of the medical records revealed Resident #4 did receive the scheduled doses of medication. During interview with LPN #115, she revealed that she did take Resident #4's remaining clindamycin medication which was to be returned to the pharma		
	#115 regarding the allegation of mi LPN #115 if she was aware of the i be thrown away, so I took them be with me, I can return them. LPN #1	dated 01/09/23, revealed the DON and sappropriation of Resident #4's clindan neident involving the clindamycin and Leause I had a toothache. I never actual 15 was suspended immediately pendir /11/23 at 12:59 P.M. and substantiated	nycin medication. The DON asked LPN #115 stated, I thought it would by took the pills. I still have them ag the investigation. The facility
	working on the first floor when she According to the witness statement	(STNA) #114's witness statement, date observed LPN #115 take some medical, LPN #115 sat at the desk and remove and then placed the cup into her bag are garbage can.	ations out of the medication room. ed the medications from the
	(continued on next page)		

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For information on the nursing home's p	plan to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG			on)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Review of LPN #116's witness statement, dated 01/09/23 at 4:10 P.M., revealed LPN #115 was observed taking Clindamycin 150 milligrams (mg) from the medication room and then popping them out of the card and into a cup, to reportedly take for a toothache. Review of LPN #115's personnel record revealed she was terminated from employment on 01/11/23 due to misappropriation of medication. During interview on 01/11/23 at 10:48 A.M., the Director of Nursing (DON) confirmed LPN #115 misappropriated Resident #4's remaining clindamycin medication. Reviewed facility policy, Abuse, Neglect, and Misappropriation, dated 07/28/20, revealed it is the policy of this 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. Investigation of Allegad Abuse: an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation. Written procedures for the allegadious staff responsible for the investigation; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; providing complete and thorough documentation of the investigation is investigation; identifying and interviewing all involved persons, including the alleged victim and residents are protected from physical and psychosocial harm during and after the investigation is climited to responding immediately to protect the allegade victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increase supervision of the allegations.		