

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to properly store, label, and date food in the kitchen. Furthermore, the facility failed to ensure the kitchen was maintained in a sanitary manner. This had the potential to affect all residents. The facility census was 38. Observation on 12/08/25 at 8:01 A.M. of the dry storage revealed a bag of oats and honey granola that was opened and undated, a bag of pasta noodles that was opened and undated, and a loaf of bread that was opened and undated. Interview on 12/08/25 at 8:03 A.M. with Dietary Manager (DM) #242 verified the granola, pasta, and bread had been opened and was not dated. Observation on 12/08/25 at 8:04 A.M. of reach in refrigerator #1 revealed the inside of the refrigerator was coated in unidentifiable liquids and food crumbs. Inside of refrigerator #1 was a bottle of barbeque sauce that was opened and undated, a bag of mozzarella that was opened and undated, a bottle of cranberry juice that was opened and undated, and a bottle of thickened apple and orange juice that were both opened and undated. Concurrent interview with DM #242 verified the refrigerator was dirty and these items were opened and undated. Observation on 12/08/25 at 8:09 A.M. of reach in freezer #1 revealed a bag of breaded pork patties that were opened, unlabeled, and undated, a bag of chicken breasts that were opened, unlabeled, and undated, and a bag of sausage links that were opened, unlabeled, and undated. Concurrent interview with Dietary Aide (DA) #243 verified these items were opened, unlabeled, and undated. Observation on 12/09/25 at 9:00 A.M. of the kitchen revealed dust and debris coating the wall and metal support for overhead piping above two coffee pots and near the food preparation area. Interview on 12/09/25 at 9:06 A.M. with DM #242 verified the dust and debris on the wall and on the overhead metal piping support. Review of the facility policy with a last revised date of February 2018 titled JAG- Food Receiving and Storage revealed food storage areas should always be clean. Furthermore, opened food should be labeled and dated.		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, resident interview, and policy review, the facility failed to ensure a clear advanced directive, and failed to ensure the advanced directive in the electronic medical record (EMR) and in the paper chart matched. This affected one Resident (#41) of 38 residents reviewed for advanced directives. The facility census was 38. Review of Resident #41's medical record revealed an admission date of 09/25/24. Diagnoses included cerebrovascular disease, hypertensive heart disease without heart failure, major depressive disorder, and vascular dementia. Review of Resident #41's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had severe cognitive impairment. Review of Resident #41's care plan with a last revision date of 09/04/25 revealed Resident #41 and or the responsible party had chosen for Resident #41 to be a full code with interventions including to call emergency services for emergency help, if needed, offer information and discuss the advanced directive and code status with the resident and family quarterly and as needed. Observation on 12/08/25 at 3:02 P.M. of the paper chart for Resident #41 revealed the first document under the advanced directives tab was a Do Not Resuscitate (DNR) order signed by the physician on 06/06/24. Further review of the paper chart revealed a document titled full code signed by Resident #41 on 07/16/25. Resident #41 was identified as a full code status the EMR. Interview on 12/09/25 at 8:54 A.M. with Licensed Practical Nurse (LPN) #260 revealed in the event of a resident needing Cardiopulmonary Resuscitation, she would first check the residents code status. Concurrently, LPN #260 verified Resident #41 had a DNR order as the first document behind the advanced directives tab in the paper chart and was a full code in the EMR. Interview on 12/10/25 at 8:20 A.M. with Social Services (SS) #208 revealed when a residents code status changes, she will update the EMR and the paper chart. SS #208 revealed she would remove the previous code status paperwork from the paper chart and update it with the new code status paperwork. Interview on 12/10/25 at 10:12 A.M. with Resident #41 revealed Resident #41 wanted to be a full code. Review of the facility policy last revised in September of 2022 titled Advanced Directives revealed advanced directives would be placed in the residents medical record and should be readily available for staff.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, resident interview, staff interview, and policy review, the facility failed to ensure the temperature inside of the facility remained between 71 and 81 degrees Fahrenheit (DF). This affected three residents (#9, #10, and #33) of seven residents reviewed for facility temperature. The facility census was 38. Observation on 12/10/25 at 2:32 P.M. of the 200 hallway revealed it felt cold in the facility. Review of the medical record for Resident #9 revealed an admission date of 08/10/23. Diagnoses included epilepsy, dementia with mood disturbances, major depressive disorder, and anxiety disorder. Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had moderately impaired cognition. Furthermore, Resident #9 was dependent for toilet hygiene, personal hygiene, and shower hygiene. Interview on 12/10/25 at 2:40 P.M. with Resident #9 revealed he felt it was cold in his bedroom. Concurrent interview with Maintenance Assistant (MA) #214 verified Resident #9's room felt cool. MA #214 further verified the temperature in the room was 69.4 degrees Fahrenheit (F). Review of the medical record for Resident #10 revealed an admission date of 06/26/19. Diagnoses included hyperlipidemia, quadriplegia, apraxia, major depressive disorder, and obstructive sleep apnea. Review of Resident #10's annual MDS assessment dated [DATE] revealed Resident #10 had moderately impaired cognition. Furthermore, Resident #10 was dependent for personal hygiene, toilet hygiene, and all mobility. Interview on 12/10/25 at 2:41 P.M. with Resident #10 revealed he felt it was cold in his bedroom. Concurrent interview with MA #214 verified Resident #10's room felt cool. MA #214 further verified the temperature in the room was 69.7 degrees Fahrenheit (F). Review of Resident #33's medical record revealed an admission date of 12/21/24. Diagnoses included Alzheimer's, hyperlipidemia, hypertension, and type two diabetes mellitus. Review of Resident #33's annual MDS assessment dated [DATE] revealed Resident #33 had intact cognition. Furthermore, Resident #33 was independent for mobility. Interview on 12/10/25 at 10:09 A.M. with Resident #33 revealed it is cold in his room, and he had reported this to the facility. He stated he had to wear multiple layers of clothes because it was so cold. Interview on 12/10/25 at 2:43 P.M. with MA #214 verified it was 69.8 degrees F in Resident #33's room. MA #24 verified building temperature should be between 71 and 81 degrees F. Review of the undated facility policy titled Maintenance of Building Temperatures / Provisions for Extreme Heat or Cold revealed the building temperature in all resident areas will be maintained between 71 and 81 degrees F.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review the facility failed to comprehensively treat residents after a fall. This deficient practice affected one (Resident #27) of three resident reviewed for accidents. The facility census was 38. Review of Resident #27 medical record revealed an admission date of 5/21/25 and medical diagnosis of Alzheimer's disease with late onset, unspecified protein-calorie malnutrition, dementia with moderate mood disturbance and agitation, anxiety, psychotic disorder with delusions, glaucoma, hypertension, muscle weakness, abnormal gait and mobility, repeated falls, and personal injury in unspecified motor-vehicle accident. Review of Resident #27 Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and was at risk for falls. Review of Resident #27 care plan last updated 12/9/25 revealed a risk for fall related to confusion related to the dementia process, impaired balance, impaired mobility, non-compliance with mobility aide, poor coordination, unsteady gait, use of psychotropic medications and poor safety awareness related to the dementia resident non-compliant with fall interventions, continued falls with non-compliance, and ambulates herself without use of call light. Interventions included for a floor mat to be placed next to bed at all times, to provide safer bed boundaries, reinforce need to call for assistance, and have commonly used articles within easy reach. Further review of the care plan revealed Resident #27 had an actual and was identified for a potential alteration in skin integrity related to incontinence, poor oral intake, and non-compliance with interventions. Review of Resident # 27 progress notes dated 12/05/25 at 9:05 P.M. revealed staff heard a cry for help, went to the resident's room and found Resident # 27 on the floor next to the bed, between the bed and wheelchair. The resident was apparently trying to walk to the bathroom and did not see the wheelchair obstructing their pathway. Resident #27 sustained an abrasion above the right eye, denied a headache or head pain, and denied any vision changes. Resident #27 was assisted to the bathroom by a Certified Nursing Assistant (CNA) and walked back to bed with supervision. The resident's emergency contact and the provider were notified of the fall at 10:28 P.M. on 12/05/25. Further review of progress notes dated 12/06/25 at 8:52 A.M. revealed the resident was on neurological checks and had sustained a skin tear above the right eye and had no complaints of pain or discomfort. Review of Resident #27 skin assessments revealed no skin assessment was completed documenting the skin tear to the right eyebrow. Attempted interview with Resident #27 on 12/19/25 at 9:00 A.M. was unsuccessful due to the residents cognitive status. Interview on 12/11/2025 at 3:34 P.M. with the Interim Director of Nursing confirmed the facility did not have a treatment plan regarding Resident #27 fall and injury above the right eye. Further interview confirmed the expectation for residents that have fallen is to have follow up care including the nurses documenting any wounds or injuries sustained as a result of a fall in a skin assessment and in a nurses note, with ongoing skin scheduled skin assessments for continued monitoring of the skin alteration. Review of facility policy, Fall- Clinical Protocol last revised march 2018 revealed the nurses shall assess and document recent injury, especially fracture or head injury. Further review revealed the staff, with the physician's guidance, will follow up on any fall with associated injury.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to properly store medication in a safe manor. This affected one (#15) resident reviewed for medication storage. The facility census was 38. Review of the medical record for Resident #15 revealed an admission on [DATE] with a readmission on [DATE]. Diagnoses included displaced intertrochanteric fracture of left femur, chronic kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) on 09/25/25 revealed Resident #15 had impaired cognition. Resident #15 required moderate assistance with activities of daily living (ADLs). Review of the care plan dated 07/21/25 revealed Resident #15 prefers to provide his own personal care and is resistant to staff assistance and refuses assistance when offered. Interventions included assisting with functional abilities as requested. Review of the Self Medication Program Assessment of Skills dated 09/30/25 revealed Resident #15 presents a danger to himself or others while self-administering medication and was not a candidate to participate in the self-medication program. Review of the physician orders dated 02/28/25 for Resident #15 revealed an order for Nystatin External Cream 100,000 units/gram, apply to red areas topically every 12 hours as needed for red areas. Review of the Treatment Administration Record (TAR) for 12/2025 revealed Resident #15 had not received Nystatin External Cream. Observation on 02/09/25 at 7:46 A.M. revealed Resident #15 sitting in recliner chair. On the bed was a medication cup with an unknown substance mixed with water. Interview on 02/09/25 at 7:46 A.M. with Resident #15 revealed the substance in the cup was his fungus cream. Resident #15 stated they give him the cream every day. Interview on 02/09/25 at 7:48 A.M. with Licensed Practical Nurse (LPN) #253 revealed the substance in the medication cup was Resident #15's Nystatin cream. LPN #253 further stated that Resident #15 was allowed to self-administer the medication per the doctor. LPN #253 confirmed there were no orders for Resident #15 to self-administer. Interview on 02/09/25 at 7:52 A.M. with Director of Nursing (DON) #779 confirmed Resident #15 did not have an order to self-administer and further confirmed the Nystatin cream had not been signed out in the TAR. Review of the facility policy titled Administering Medications dated April 2025, revealed residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they can do so safely.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to ensure residents received the correct portions during meal service and further failed to ensure liquids were thickened per the physician's orders. This affected three (#37, #38 and #18) of three residents revealed for diets to meet the resident needs. The facility census was 38. 1. Review of Resident #37 ' s medical record revealed an admission date of 04/12/17. Diagnoses included esophageal varices without bleeding, muscle wasting and atrophy, dysphagia, and functional dyspepsia. Review of Resident #37 ' s physician orders revealed a diet order for a regular diet, pureed texture, with thin liquids. Review of Resident #37 ' s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 required a mechanically altered diet. Review of Resident #37 ' s care plan dated 10/10/25 revealed Resident #37 had an altered nutritional status as evidenced by the need for a mechanically altered diet with interventions that included to provide a diet per the Registered Dietitians recommendations and the physicians orders and to honor meal preferences. 2. Review of Resident #38 ' s medical record revealed an admission date of 03/16/16. Diagnoses included paranoid schizophrenia, muscular dystrophy, dental caries, and dysphagia oropharyngeal phase. Review of Resident #38 ' s physician orders revealed a diet order for a regular diet, pureed texture, with thin liquids. Review of Resident #38 ' s quarterly MDS assessment dated [DATE] revealed Resident #38 required a mechanically altered diet. Review of Resident #38 ' s care plan with a last revision date of 12/10/25 revealed Resident #38 had an altered nutritional status as evidenced by the need for a mechanically altered diet with interventions that included to provide a diet per the Registered Dietitians recommendations and the physicians orders and to honor meal preferences. Review of the week two menus and spreadsheets revealed residents on a pureed diet were to have three ounces of pureed sliced turkey with gravy, four ounces of mashed potatoes, four ounces of pureed green beans, two ounces of pureed dinner roll, two ounces pureed brownie, eight ounces of coffee/tea, and one packet of margarine for the lunch meal on 12/08/25. Observation on 12/08/25 at 11:35 A.M. of the meal preparation revealed Dietary Aide (DA) #246 placed two four ounce scoops of green beans into the blender with an unmeasured amount of water to puree the green beans. DA #246 poured the green beans into two separate bowls and placed the covered bowls into the warmer. DA #246 sent the blender and its parts through the dishwasher and then pureed six hot slices of deli turkey with an unmeasured amount of water. Interview on 12/08/25 at 12:04 P.M. with DA #246 verified she used an unmeasured amount of water (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to puree the green beans and an unmeasured amount of gravy to puree the deli turkey. DA #246 stated she knew how much liquid to add based on what the food looked like. Interview with Dietary Manager (DM) #242 on 12/08/25 at 12:04 P.M. verified the previously pureed green beans measured out to slightly more than half of a half cup. Furthermore, DM #242 verified the pureed turkey did not completely fill the one third cup. Observation on 12/08/25 at 12:15 P.M. revealed the dietary staff served Resident #37 and Resident #38 the food they pureed. Interview on 12/11/25 at 10:57 A.M. with Dietician #207 revealed the facility should be following the menu and serving sizes. She stated there are the same nutritional components before and after pureeing food. Dietician #207 stated best practice would be to puree more food so that the food appears in decent volumes and appetizing. She stated if residents are not receiving the correct portion sizes, they may experience weight loss, it could delay wound healing, and could affect overall health. 3. Review of the medical record for Resident #18 revealed an admission on [DATE]. Diagnoses included Huntington's Disease, anorexia, and dysphagia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #18 had severe cognitive impairment. Resident #18 was dependent for activities of daily living (ADL) and required a mechanically altered diet. Review of the care plan dated 05/24/23 revealed Resident #18 had an ADL self-care performance deficit related to Huntington's disease, impaired balance, limited mobility, functional quadriplegia, and muscle spasms. Interventions included partial to moderate assistance with eating. Further review of the care plan revealed Resident #18 had a potential for episodes of nutritional problems, abdominal pain, indigestion, nausea and vomiting, diarrhea, constipation, and dysphagia, related to constipation, nausea, and dysphagia. Interventions included following diet per Registered Dietitian recommendation and physician order and encouraging fluid intake at and between meals. Additional review of the care plan revealed Resident #18 had altered nutritional status as evidence by Huntington ' s disease, and need for mechanically altered diet and thickened liquids. Interventions included monitoring and recording by mouth intake, encouraging adequate fluid intake during and between meals, and giving diet per Registered Dietician recommendations and physician order. Review of the physician ' s order dated 06/03/23 revealed Resident #18 was on a mechanical soft diet with nectar thickened liquids. Resident #18 was to have strict supervision with all by mouth intake. Review of the speech therapy evaluation and treatment plan dated 11/11/25 revealed Resident #18 had dysphagia due to Huntington ' s Disease and required a mechanical soft diet with nectar thick liquids. Observation on 12/09/25 at 2:27 P.M. of Resident #18 ' s room revealed a water pitcher on bed side table that was half full of water. Interview on 12/09/25 at 2:31 P.M. with Certified Nursing Assistant (CNA) #271 confirmed the liquid in Resident #18 ' s room was not nectar thick. CNA #271 further confirmed Resident #18 was to be (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervised with all oral intake. Interview on 12/09/25 at 3:33 P.M. with Director of Nursing (DON) #779 revealed Resident #18 was able to hold a water pitcher independently. DON further confirmed Resident #18 was to receive nectar thickened liquids, with total supervision due to the potential for aspiration. Review of the facility policy titled Therapeutic Diets dated 10/2017 revealed, a therapeutic diet is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition and should match what the residents are receiving.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Marion Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 409 Bellfontaine Avenue Marion, OH 43302	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and review of the facility policy, the facility failed to ensure medications were documented in the Treatment Administration Record (TAR). This affected one (#15) of four residents reviewed for medication administration. The facility census was 38. Review of the medical record for Resident #15 revealed an admission on [DATE] with a readmission on [DATE]. Diagnoses included displaced intertrochanteric fracture of left femur, chronic kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) on 09/25/25 revealed Resident #15 had impaired cognition. Resident #15 required moderate assistance with activities of daily living (ADLs). Review of the care plan dated 07/21/25 revealed Resident #15 prefers to provide his own personal care and is resistant to staff assistance and refuses assistance when offered. Interventions included assisting with functional abilities as requested. Review of the Self Medication Program Assessment of Skills dated 09/30/25 revealed Resident #15 presents a danger to himself or others while self-administering medication and was not a candidate to participate in the self-medication program. Review of the physician orders dated 02/28/25 for Resident #15 revealed an order for Nystatin External Cream 100,000 units/gram, apply to red areas topically every 12 hours as needed for red areas. Review of the Treatment Administration Record (TAR) for 12/2025 revealed Resident #15 had not received Nystatin External Cream. Observation on 02/09/25 at 7:46 A.M. revealed Resident #15 sitting in recliner chair. On the bed was a medication cup with an unknown substance mixed with water. Interview on 02/09/25 at 7:46 A.M. with Resident #15 revealed the substance in the cup was his fungus cream. Resident #15 stated they give him the cream every day. Interview on 02/09/25 at 7:48 A.M. with Licensed Practical Nurse (LPN) #253 revealed the substance in the medication cup was Resident #15's Nystatin cream. LPN #253 further stated that Resident #15 was allowed to self-administer the medication per the doctor. LPN #253 confirmed there were no orders for Resident #15 to self-administer. Interview on 02/09/25 at 7:52 A.M. with Director of Nursing (DON) #779 confirmed Resident #15 did not have an order to self-administer and further confirmed the Nystatin cream had not been signed out in the TAR. Review of the facility policy titled Administering Medications dated April 2025, revealed topical medications used in treatments are recorded on the residents TAR.		