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	12/08/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review and interview, the facility failed to ensure resident safety during facility provided transportation to prevent injury. In addition, the facility failed to ensure fall interventions were in place for residents at risk for falls. This affected two residents (#1 and #15) of three residents reviewed for falls. The facility census was 117. Actual Harm occurred on 10/27/25 when Resident #1, a resident dependent on staff for transportation, was on her way back to the facility from an appointment at a local hospital when Transport Aide (TA) #118 failed to ensure the wheel straps on the left side of Resident #1's wheelchair were secured appropriately. This resulted in Resident #1 being dislodged from her wheelchair as the bus turned, falling and hitting her head. Resident #1 was transported to the local hospital emergency room where she required medical treatment including 10 staples to a head laceration. Findings include:1. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, paroxysmal atrial fibrillation and hypothyroidism.Review of a care plan revised on 08/18/25 revealed Resident #1 was at risk for falls related to cerebral vascular incident, generalized weakness, medications, pain, and need for assistance with activities of daily living. The goal was to reduce Resident #1's risk of injury through the next review. Interventions included but were not limited to anti-tippers to wheelchair, non-skid footwear, use call light, and ensure resident's room will be free from hazards.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1's cognition was intact. The assessment revealed the resident had no behaviors and used a wheelchair for mobility.Review of the physician's orders revealed an order dated 10/03/25 for Resident #1 to receive Eliquis (a blood thinning medication) five milligrams (mg) by mouth every morning and at bedtime related to cardiomyopathy.There was no evidence Resident #1 had a care plan in place related to her use of a blood thinning medication that would include monitoring for abnormal signs or symptoms related to the resident's medical condition and use of a blood thinning medication.Review of a nursing note and corresponding incident report both dated 10/27/25 at 12:40 P.M. by the Director of Nursing (DON) revealed Resident #1 was on her way to an appointment with TA #118. TA #118 noticed a strap came loose and Resident #1 started to move backwards which caused the resident's wheelchair to upset. Resident #1 hit her head causing a laceration. The transportation assistant applied pressure with first aide gauze on the bus, and the driver got the bus pulled to safety, removed the wheelchair and assisted Resident #1 back into the wheelchair. Resident #1 maintained pressure on the wound until the driver arrived at a local emergency room per Medical Director (MD) #500. The note included Resident #1's family was updated with no concerns. TA #118 was with Resident #1, Resident #1 remained alert and oriented to person, place, and time with complaints of a mild headache and wanted to go home. Resident #1 was interviewed via phone and stated she slid back and the chair upset. Review of a nursing note dated 10/27/25 at 6:10 P.M. authored by Licensed Practical Nurse (LPN) #101 revealed Resident #1 returned to the facility from the emergency department with 10 staples to her posterior head, to remain (in place for 10-14 days). The area was clean, staples intact, some scant bleeding was noted when assessed. Instructions included, do not get the area wet for 24 hours, no other skin issues noted upon skin assessment. Vitals were obtained and no new orders.Review of a social service progress note dated 10/28/25 at 12:05 P.M. by Social Worker (SW) #131 revealed Resident #1 had been speaking to the unit manager when SW #131 approached. The note included Resident #1 stated she had some pain between her shoulders rating at a three out of 10 (this pain was a result of the resident's fall out of her wheelchair on 10/27/25). Nursing was made aware and planned to apply Biofreeze to the area. Review of a nursing note dated 10/28/25 at 5:20 P.M. by Social Worker (SW) #131 revealed Resident #1 refused a shower due to not feeling well, this nurse spoke with the resident who stated she was having head and neck pain (the pain was related to the resident's fall out of her wheelchair on 10/27/25) and would like to wait. MD #500 and representative were aware.Review of a social services note dated 10/29/25 at 11:13 A.M. by SW #131 revealed Resident #1 had an appointment later in the day. The note included when asked if she had reservations attending appointments, she denied any and stated she trusted the bus driver and was in good hands. Resident #1 stated she had some pain between her shoulders rating at a two, reported the day prior Biofreeze was applied and alleviated the pain, nursing was made aware and planned to put Biofreeze on the area. Review of a performance improvement form dated 10/30/25 revealed TA #118 was terminated from the facility. Interview on 12/03/25 at 4:00 P.M. with the DON revealed Resident #1 was in the transport van when