

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 02/12/2026
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 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility investigation, staff interview, and policy review, the facility failed to ensure a possible situation of neglect was reported to the State survey agency, as required, when a resident choked during a meal resulting in the resident's death. This affected one resident (#128) of two residents reviewed for death. Findings include: Review of Resident #128's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a malignant neoplasm of the prostate and obesity. Review of Resident #128's advanced directives revealed the resident's code status was a Do Not Resuscitate Comfort Care Arrest (full treatment provided, including resuscitation efforts, until the resident experienced cardiac or respiratory arrest, when all life-saving interventions stop). The advanced directive had been signed into place by an advanced level provider on [DATE]. Review of Resident #128's physician's orders revealed he was to receive a regular diet, with regular texture, and thin liquids. That order had been in place, since [DATE]. Review of Resident #128's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He only required set up or clean up assistance with eating. He was not known to have any coughing or choking with meals or his medications. He had no complaints of difficulty or pain when swallowing and was not receiving speech therapy services at the time of the assessment. Review of Resident #128's care plans revealed the resident was at risk for an altered nutritional status related to being above his ideal body weight, having the diagnosis of diabetes mellitus, and a history of weight loss. The care plan originated on [DATE] and the interventions included providing meals based on his preference and as ordered. They were to provide assistance with meals as needed. He also had a dental care plan in place that indicated he was edentulous (no natural teeth). Review of Resident #128's progress notes revealed a nurse's note by Licensed Practical Nurse (LPN) #100 dated [DATE] at 2:20 P.M. revealed the resident was given his lunch tray at 12:36 P.M. by a certified nursing assistant (CNA). The resident was sitting up right with no concerns noted at that time. At 12:38 P.M., a CNA took a visitor in to see the resident and no concerns were noted at that time. At 12:54 P.M., a CNA went into to check on the resident and noted the resident was showing signs of choking. His face was noted to be losing color and, when asked if he was choking, the resident nodded his head up and down. The CNA yelled outside the room for help, then performed back thrusts. Another CNA came into the room and performed back thrusts to the resident, until another staff member could assist them in repositioning the resident to perform the Heimlich maneuver. At 12:55 P.M., the nurses validated the resident's code status, as being a DNRCC-A, before entering the room, positioning the resident on the side of the bed, and began performing the Heimlich maneuver on the resident. His oral cavity was assessed and no foreign object was visible. Resident #128 became unresponsive and had no pulse noted. At 12:56 P.M., 911 was called. The Heimlich maneuver and back thrusts continued without success in opening the resident's airway. At 1:01 P.M.,</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365687	Facility ID: 365687 If continuation sheet Page 1 of 6

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 02/12/2026
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 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Emergency Medical Services (EMS) arrived on scene and took over. An assessment was completed and an Automated External Defibrillator (AED) was applied confirming the resident had no pulse. At 1:17 P.M., the resident was pronounced deceased by EMS, with ER doctor assisting to confirm the death. The physician and family were notified. Prior to the choking incident, the resident was eating blueberries brought in by his son, yogurt, and a few bites of chicken off of the chicken leg that was served on the resident's lunch tray. The chicken leg was assessed and the bone was still on tray. The chicken was noted to be moist. Review of the facility's investigation into Resident #128's choking incident on [DATE] revealed an incident report pertaining to the incident and witness statements were obtained. The facility also included a timeline of the incident's occurrences. The incident report was reflective of the information documented under the nurse's progress note, which documented the incident. The incident report was completed by the facility's interim Director of Nursing (DON). Review of the witness statements obtained by the facility, as part of their investigation, revealed statements were obtained from the staff member that delivered Resident #128's lunch tray to him on [DATE], the CNA that found the resident choking, the nurses that responded, as well as other staff members working on the resident's unit that day. Review of the witness statement from CNA #115 revealed she delivered Resident #128's tray to him and then was the CNA that took a visitor into the resident's room to see him, after his lunch tray had been provided. At that time, the resident was eating blueberries that had been provided by his family, in addition to the lunch meal he was served. Review of a witness statement from CNA #150 revealed she was picking up trays and entered Resident #128's room, when she noticed he was sitting upright in bed and his face was turning blue. He was also pointing and pounding on his throat/ chest area. The CNA immediately yelled for help and sat the resident up in bed, where she could perform back thrusts. The nurses came in and took over. The resident was noted to be eating blueberries and yogurt his son had brought in earlier that day. Review of a witness statement from LPN #175 for a date and time of incident being [DATE] at 1:10 P.M. revealed nursing staff was called to Resident #128's room due to the resident choking. Upon entering his room, the resident was found unresponsive with a pulse and no respirations. The Heimlich maneuver was performed without success. All attempts to dislodge the choking material were unsuccessful. The local EMS arrived and called the resident's time of death at 1:17 P.M. On [DATE] at 12:53 P.M., an interview with the facility's Administrator revealed they did not submit a self-reporting incident (SRI) to the State survey agency pertaining to the choking incident involving Resident #128 on [DATE]. He questioned if that was something they were required to report, if their investigation determined that no wrong doing had occurred, and the facility felt the staff responded appropriately to the incident. He acknowledged it was an unusual occurrence in the facility that resulted in a resident's death and should have been reported as possible neglect of the resident. Any subsequent investigation the facility conducted could then be reported to the State survey agency with their conclusion determining if neglect had actually occurred. Review of the facility's policy on Abuse, Neglect, and Exploitation (revised [DATE]) revealed neglect meant failure of the facility, its employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. An alleged violation was defined as a situation or occurrence that was observed or reported by staff, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source. Under the reporting/ response section of the policy, the facility would have written procedures that include reporting of alleged violations to the Administrator, state agency, adult protective services and to all</p> <p>(continued on next page)</p>		

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 02/12/2026
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 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>other required agencies within specified timeframes as required by state and federal regulations. They were to report immediately, but no later than two hours after the allegation was made, if the events that cause the allegation involved abuse, or resulted in serious bodily injury. The Administrator would follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2739421.</p>		

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 02/12/2026
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 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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on review of the facility's cycle menus, observation, interview, and policy review, the facility failed to ensure meals were provided as per the menu and all substitutions of the meal that deviated from the planned menu were recorded and kept on record as required. This had the potential to affect all but 11 residents (#25, #26, #54, #55, #57, #58, #65, #66, #68, #119, and #127), who the facility identified as being on nothing by mouth (NPO) diets, and did not receive meals from the kitchen. The facility's census was 127. Findings include: Review of the facility's cycle menu for Week #1 of 2025- 2026 revealed the lunch menu for Wednesday 02/11/26 was to be cranberry orange chicken, roasted Brussels sprouts, garlic and rosemary roasted red skin potatoes, dinner roll, and Mandarin oranges. The alternate for that meal was cheese ravioli with marinara sauce and a tossed salad with dressing. The menu included a message that indicated meals were subject to change without notice due to product availability. On 02/11/26 at 11:21 A.M., a visit was made to the facility's kitchen for observation of the meal process for the lunch meal being served that day. The intent of the visit was to ensure the meal was being served as per the menu and proper portion sizes were being provided. Both had been mentioned as concerns and were part of the information obtained when the complaint was filed. Dietary staff were asked to provide the spreadsheet for the day's menu to be able to verify proper serving sizes. The spreadsheet provided was not the spreadsheet that correlated with the Week #1 menu for 2025-2026 that was being used for the current week's menu. The spreadsheet included a lunch meal for Tuesday (Day 10) that had been pulled from the 2023- 2024 Diet Guide Sheet. It had the following food items listed as part of that meal: smothered chicken thigh, poultry gravy, broccoli florets, mashed potatoes, dinner roll, and sliced pears. Observations confirmed that was the food items being served and not any of the food items listed as part of the facility's Week #1 cycle menu from 2025-2026 that the facility provided as this week's menu. Review of the facility's Menu Substitution Log for November 2025 thru January 2026 revealed multiple food substitutions had been recorded as having been made during that three month period. In all, 27 meal substitutes had been made deviating from the facility's planned cycle menu planned by a dietitian they were to follow. There had not been a Menu Substitution Log provided for February 2026 to reflect any changes to the menu that had occurred that month. The facility's Administrator obtained a new copy of the Menu Substitution Log for December 2025 thru January 2026 that had previously been provided and added the substitutions that had been made for the lunch meal served on 02/11/26. The substitutions added for 02/11/26 revealed the chicken thigh had been omitted and substituted with a chicken breast. Also omitted and replaced with another food item was the Brussels sprouts that was replaced with broccoli and roasted potatoes for mashed potatoes. It did not specific to indicate that cranberry orange chicken was substituted with smothered chicken or that the Mandarin oranges had also been omitted and replaced with pears. On 02/11/26 at 3:00 P.M., an interview with the facility's Administrator revealed the facility does use cycle menus and they were currently on Week #1 for the 2025-2026 menu. He stated the week of the menu they were using did not always match the week of the month explaining why Week #1 was currently being followed when it was actually Week #2 of the current month. They just rotate through them week after week, which causes them to be off. He confirmed the meal being followed for lunch that day was actually on the Week #1 menu for the 2025-2026 cycle menu. He further confirmed that lunch meal for Wednesday 02/11/26 should have been cranberry orange chicken, roasted Brussels sprouts, garlic and rosemary roasted red skin potatoes, a dinner roll, and Mandarin oranges. He was informed the meal served today for the lunch meal was smothered chicken, mashed potatoes, broccoli, and pears. It did not include the</p> <p>(continued on next page)</p>		

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 02/12/2026
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 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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>cranberry orange chicken, Brussel sprouts, red skin potatoes, and Mandarin oranges, as was on the menu. He further confirmed the Menu Substitution Log he provided with the day's substitution did not even mention the Mandarin oranges that had been replaced with the pears. He also acknowledged that the spreadsheet that was provided for that day's lunch meal was from 2023-2024 and was not the spreadsheet for Wednesday's lunch meal from the 2025-2026 menu. On 02/11/26 at 3:20 P.M., an interview with Regional Nurse #200 also confirmed the meal served to the residents for lunch on 02/11/26 was not consistent with the facility's cycle menu for Week #1 of the 2025-2026. She further confirmed the Menu Substitution Log did not properly record the Mandarin oranges being omitted and replaced with pears, as was served today, and not properly recording the meal as served. She acknowledged there were a lot of substitutions being made deviating from the facility's planned cycle menu during the past several months. She stated she would have to check to see what the issue was with ordering of food supplies, since they were making so many changes to the planned menus. She acknowledged residents had verbalized concerns that they were not being provided meals, as per the menu, and were saying they were not being informed when substitutions were being made. She reported planned meals should not be changed, unless the food items to be served were not available, and that should not be a common occurrence. On 02/12/26 at 9:09 A.M., an interview with Dietary [NAME] #225 revealed she was the cook on duty for the lunch meal served on 02/11/26. She was asked what was the meal served to the residents for that meal and why it deviated from the planned cycle menu. She reported they had smothered chicken, broccoli, mashed potatoes, dinner roll, and pears. She was asked what the chicken was smothered in and reported onions and gravy. They were supposed to have cranberry orange chicken, but the residents do not prefer that. It was decided during resident council at one time that they did not like that meal on the menu. She reported they did not have Brussels sprouts because 75% of the residents did not like them. They preferred cabbage or sauerkraut over that. Same with the red skin potatoes. They had them so often the residents were getting tired of them. She reported the majority of the substitutions being done were due to resident preferences. She was asked to clarify which residents preferences were being honored and she mentioned the names of a few residents that attended the resident council meetings. She indicated they typically had 15-25 residents who attended those meetings and they tried to follow what those residents suggested in regards to the menus. There was a rare occasion that they may not have something available from their food supplier, but that did not happen often. If there food service company was out of a particular food item, they would send something similar as a substitute. She reported the residents were made aware of the upcoming meals through receiving the daily chronicle. The daily chronicle would give them the next week's menus for all three meals for that seven day period. There were times when a menu would be changed, based on known resident preferences, that may not be communicated to the residents. She acknowledged it may be frustrating for residents to be informed they were going to be having a certain meal item, only to have it substituted with something else based on resident preference. She further acknowledged the number of residents actually attending resident council were a small sample size of the 127 residents that resided in the building. Those preferences being reported during resident council may not represent the majority of the residents, as a whole. She identified by looking at the Menu Substitution Logs that spinach, Brussels sprouts, roasted potatoes, broccoli, and shrimp were some of the food items the residents did not prefer. She acknowledged, just because the limited number of residents attending the resident council meetings did not like some of those food items, it did not mean other residents would not enjoy them. She agreed the dietary staff should try to serve the meal, as per the cycle menu, and make limited substitutions only based on availability of food or other unforeseen reasons the</p> <p>(continued on next page)</p>		

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 02/12/2026
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 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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>food items on the planned menus could not be served. If they were aware of menu items resident council members were reporting they did not prefer, the kitchen could ensure they had a like substitute for those food items available upon request. Having a second vegetable choice in place of Brussels sprouts or spinach may be a better option than never cooking those items, when some residents may enjoy them. On 02/12/26 at 4:00 P.M., an interview with Resident #118 revealed it was frustrating to him to receive a planned menu at the beginning of the week, when those menus were often changed without him being aware. He stated it typically happened two or three times a week that the menu would change without the residents being notified. He reported even the residents on the same hall were not receiving the same food items. He would be out in the designated smoking area and would ask another resident how they liked a particular food item. The resident in return would tell him that they did not get that to eat and would have liked to. He stated they were never given an explanation, as to why a meal was not served according to the menu. He would hear that the cook just did not make enough and ran out before all the residents had been served. Review of the facility's policy on Menus (revised October 2022) revealed menus would be prepared in advance to meet the nutritional needs of the residents in accordance with established national guidelines. Menus would be periodically presented for resident review, including the resident council, menu review meetings, or other review board as indicated by the facility. The menu would identify the primary meal, the alternate meal, and any always offered food and beverage items. A registered dietitian (RD) or other clinically qualified nutrition professional reviewed and approved the menus. The RD or other clinically qualified nutrition professional would adjust the individual meal plan to meet the individual requests, as appropriate. Menus would be served as written, unless a substitution was provided in response to preference, unavailability of an item, or a special meal. A menu substitution log would be maintained on file and kept per state regulations. This deficiency represents non-compliance investigated under Complaint Number 2707159.</p>		