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	05/28/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview and record review the facility failed to ensure a resident assessment was completed that accurately reflected the resident's status at the time of the assessment. This affected one resident (#102) of three sampled for Minimum Data Set (MDS) accuracy. The facility census was 122.Findings include: Review of the medical record for Resident #102 revealed an admission date of 01/15/26 diagnoses including acute and chronic respiratory failure with hypoxia, dependence on respirator (ventilator), Parkinson's disease, anemia, tracheostomy status, gastrostomy status, contracture of muscle, right lower leg, left lower leg, right upper arm and left upper arm, neuromuscular dysfunction of the bladder, and major depressive disorder. Review of Resident #102's quarterly Minimum Data Set (MDS) assessment, dated 04/15/26, revealed Resident #102 had severely impaired cognition. Further review of the MDS revealed Resident #102 was dependent on facility staff for all activities of daily living (ADLs)and indicated the resident had no impairments to her range of motion (ROM).Review of Resident #102's physician's progress note dated 01/15/26 written by Physician #403 revealed the resident had marked contractures of her upper and lower extremities.Review of the physical therapy evaluation completed on 01/16/26 by Physical Therapist #404 revealed Resident #102 had contractures to all joints of her bilateral lower extremities.Review of the occupational therapy evaluation completed on 01/16/26 by Occupational Therapist #406 revealed Resident #102 had contractures to both shoulders, elbows ,wrists and hands.In an interview on 05/20/26 at 9:30 A.M. Nurse Practitioner (NP) #401 revealed Resident #102 was admitted with severe contractures to her arms and legs.In an interview on 05/27/26 at 1:05 P.M. Therapy Program Director and Certified Occupational Therapy Assistant #405 revealed Resident #102 was admitted with contractures in her legs and arms.In an interview on 05/27/26 at 1:30 P.M. Nursing Restorative Aide #334 revealed Resident #102 had contractures since she was admitted to the facility in both her arms and legs. In an Interview on 05/27/26 at 4:00 P.M. Regional Nurse #402 verified the MDS for 04/15/26 is marked incorrectly should have been marked as ROM impairment to both sides for both upper and lower extremities.An observation on 05/20/26 at 11:45 A.M. revealed Resident #102 in bed tilted to her right side with inside of right knee visible. Resident #102 had a small cushion between her thighs to relieve pressure to her knees. Resident #102's bilateral arms and legs are observed to have contractures at all joints.Review of the policy titled MDS policy dated 01/24/24 revealed it was the policy of the facility to utilize the Minimum Data Set 3.0 Resident Assessment Instrument manual as the source document for MDS completion. This deficiency represents non-compliance investigated under Complaint Number #3017045.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review the facility failed to develop a person centered care plan that met the resident's medical and physical care needs related to contractures and failed to implement the Activities of Daily Living (ADL) care plan as it was written when providing care to the resident. this affected on e resident (#102) of three sampled for care planning. The facility census was 122.Findings include: Review of the medical record for Resident #102 revealed an admission date of 01/15/26 diagnoses including acute and chronic respiratory failure with hypoxia, dependence on respirator (ventilator), Parkinson's disease, anemia, tracheostomy status, gastrostomy status, contracture of muscle, right lower leg, left lower leg, right upper arm and left upper arm, neuromuscular dysfunction of the bladder, and major depressive disorder. Review of Resident #102's quarterly Minimum Data Set (MDS) assessment, dated 04/15/26, revealed Resident #102 had severely impaired cognition. Further review of the MDS revealed Resident #102 was dependent on facility staff for all activities of daily living (ADLs)and indicated the resident had no impairments to her range of motion (ROM).Review of Resident #102's physician's progress note dated 01/15/26 written by Physician #403 revealed the resident had marked contractures of her upper and lower extremities.Review of Resident #102's plan of care for ADL self-care performance deficit dated 01/15/26 revealed Resident #102 was dependent on facility staff for all ADLs. Interventions included two-person assistance with bed mobility, toileting hygiene and bathing, and two-person assistance and mechanical lift for transfers. Further review of Resident #102's plan of care revealed no care plan for Resident #102's upper and lower extremity contractures.Review of Resident #102's physician's progress note dated 01/15/26 written by Physician #403 revealed the resident had marked contractures of her upper and lower extremities.Review of the physical therapy evaluation completed on 01/16/26 by Physical Therapist #404 revealed Resident #102 had contractures to all joints of her bilateral lower extremities.Review of the occupational therapy evaluation completed on 01/16/26 by Occupational Therapist #406 revealed Resident #102 had contractures to both shoulders, elbows ,wrists and hands.In an interview on 05/20/26 at 9:30 A.M. Nurse Practitioner (NP) #401 revealed Resident #102 was admitted with severe contractures to her arms and legs.An interview attempted on 05/20 26 at 11:45 A.M. with Resident #102 revealed resident to be nonverbal. In an interview on 05/21/26 at 9:33A.M. Registered Nurse (RN) #278 revealed she was changing the resident's catheter and had positioned the resident at the edge of the bed on her right side with her hip at the resident's side so that she could see to change her catheter and when she went to separate the SR's legs she heard a grinding noise that sounded like it was coming from the hip and immediately stopped the procedure. Certified Nursing Assistants # 308 and #202 were with her at that time but did not have their hands on the resident. In an interview on 05/21/26 at 2:42 P.M. CNA #202 revealed she was in the room when the nurse was attempting to insert the resident's catheter and was standing back out of the way in case she needed to get something for the nurse. Registered Nurse (RN) #278 was trying to move her legs apart when they heard a kind of popping/grinding noise. RN #278 immediately stopped what she was doing and called to have the resident sent to the hospital. She could not see the resident's face when she heard the noise, but the resident did not move or make any sound. They received education about passive ROM after the incident.In an interview on 05/21/26 at 3:31 P.M. CNA #308 revealed they were doing checks and changes and found the resident's bed wet because her catheter was leaking. RN #278 came in and placed pillows to position the resident and was trying to spread her legs to replace the catheter and they heard a popping grinding noise. CNA #308 stated that she was standing by the bed but did not have her hands on the resident. RN #278 was not pulling on the resident hard just trying to spread her legs. The resident's vital signs were normal and CNA #308 stated she did not see grimacing or hear the resident make noise or see her cry. Crying silent tears is usually how they know the resident is in pain. CNA #308 stated she did not feel the nurse did (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything to cause the injury.In an interview on 05/27/26 at 1:05 P.M. Therapy Program Director and Certified Occupational Therapy Assistant #405 revealed Resident #102 was admitted with contractures in her legs and arms.In an interview on 05/27/26 at 1:30 P.M. Nursing Restorative Aide #334 revealed Resident #102 had contractures since she was admitted to the facility in both her arms and legs. In an interview on 05/27/26 at 4:00 P.M. Regional Nurse #402 revealed her expectation of the care plan is that it paints a picture of the resident and the care that they are to receive, and the intent is for it to be a delivery guide for care. Resident 102's care plan should have been updated to reflect that she would do better with one person doing her catheter insertion because the resident would be more uncomfortable and harder to catheterize if a second person was holding her leg in position. Regional Nurse #402 stated she would update care plan to reflect that the resident would require one to people.An observation on 05/20/26 at 11:45 A.M. revealed Resident #102 in bed tilted to her right side with inside of right knee visible. Resident #102 had a small cushion between her thighs to relieve pressure to her knees. Resident #102's bilateral arms and legs are observed to have contractures at all joints.Review of the policy titled Comprehensive Care Plan dated 01/01/21 and revised 06/30/22 revealed the care plan was to describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This deficiency represents non-compliance investigated under Complaint Number #3017045.