

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  04/25/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47985</p> <p>Based on interview, observations and policy review, the facility failed to maintain the shower room and resident rooms in a clean and sanitary manner. This affected one (#43) of two residents reviewed for physical environment. The facility census was 124.</p> <p>Findings include:</p> <p>Record review revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including encounter for orthopedic aftercare, chronic obstructive pulmonary disease, and hypertension.</p> <p>Review of an admission minimum data set (MDS) completed on 03/27/25 revealed Resident #43's cognition remained intact.</p> <p>Interview on 04/21/25 at 3:07 P.M. with Resident #43 revealed sometimes the shower rooms are not cleaned well, and she had a stain on her shower curtain since her admission.</p> <p>Interview and tour on 04/23/25 at 4:01 P.M. with Housekeeping Supervisor (HS) #201 and Maintenance Staff (MS) #567 revealed the first-floor shower room had a quarter-sized, soft bowel movement on the floor next to the drain in the third stall, and a used washcloth hanging over the handrail of the second stall. HS #201 confirmed the findings and stated housekeeping staff mop the floors each morning and scrub the floors once per week, but in between residents, the floor staff should clean the shower room. The tour continued to Resident #43's room where a round stain was noted to the bottom right of her shower curtain. The observation was confirmed by HS #201 and MS #567.</p> <p>Review of a statement dated 04/23/25 with no time provided by Certified Nursing Assistant (CNA) #531 revealed she gave Resident #43 a shower and had taken her back to her room to help her get ready and was going to clean the shower room after.</p> <p>Interview on 04/24/25 at 4:03 P.M. with MS #567 confirmed after observing the first-floor shower room during the tour, Resident #43's room was observed directly after with no sign of a CNA or Resident #43 in her room or the shower room.</p> <p>Review of a policy titled Safe and Homelike Environment dated 01/01/22 revealed the facility will provide a safe, clean, homelike, and comfortable environment and ensure the building and equipment are kept sanitary.</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
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<p>F 0607</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>07316</p> <p>Based on review of employee personnel files, review of the background check monitoring log, staff interview, and policy review, the facility failed to implement their criminal background check policy for one employee. This had the potential to affect all 124 residents.</p> <p>Findings include:</p> <p>Review of the personnel file for Registered Nurse (RN) #513 revealed she was hired on 05/14/24. There was no evidence that the facility determined whether RN #513 had resided in the state for the past five years.</p> <p>Review of the Background Check Monitoring Log revealed a Federal Bureau of Investigation (FBI) background check was not completed. It indicated that only a state Bureau of Criminal Investigation (BCI) check was completed with no findings. The facility had also conducted a background check with the Office of Inspector General (OIG) and the System for Award Management (SAM) on RN #513 at the time of hire with no findings.</p> <p>Interview with the Administrator on 04/24/25 at 1:19 P.M. revealed RN #513 did not reside in the state when hired and did not move to Ohio until August 2024. He confirmed an FBI background check was not done and should have been per state law. He stated that RN #513 would not work until an FBI background check was completed.</p> <p>Interview with the Administrator on 04/24/25 at 2:06 P.M. revealed an FBI background check was completed for RN #513 with no findings.</p> <p>Interview with the Administrator on 04/24/25 at 4:10 P.M. revealed that, at the time RN #513 was hired, the facility was not using the system they are now where they verify residency for the past seven years in writing. He stated at that time they only asked the employee if they had lived in Ohio for the past five years but there was no documentation of this. He also stated the Human Resource employee in charge of this at the time RN #513 was hired no longer works in that position and there is a new Human Resource employee.</p> <p>Review of the facility policy titled Criminal Background Checks dated 09/22/20 and revised 01/01/22 revealed it is the company's guideline that resident abuse, neglect, or misappropriation of resident property should not be tolerated. To ensure the safety of our residents, all employees will undergo a criminal background check before an employment offer is finalized. If your state has a law regarding criminal background checks, you should follow that state regulation.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</b></p> <p>Based on observation, record review, interview and policy review the facility failed to ensure minimum data set (MDS) assessments were completed accurately for falls, dental status, catheter and continence status. This affected three (#86, #104, and #178) of four residents reviewed for accurate assessments. The facility census was 124.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #178 admitted to the facility on [DATE] with diagnoses including occlusion and stenosis of right carotid artery, peripheral vascular disease, atrial fibrillation, and benign prostatic hyperplasia.</p> <p>Review of a nursing note dated 04/01/25 at 1:00 P.M. by Unit Manager (UM) #595 revealed Resident #178 admitted to the facility with a #16 French (the size of the catheter) indwelling catheter for urinary retention.</p> <p>Review of a Urinary Continence Evaluation dated 04/08/25 at 4:47 P.M. revealed Resident #178 was always continent and did not have a urinary catheter in use.</p> <p>Review of an admission MDS dated [DATE] revealed Resident #178's cognition remained intact, he did not have an indwelling catheter, and his urinary continence was not rated.</p> <p>Review of orders revealed no evidence of orders to care for Resident #178's urinary catheter.</p> <p>Interview on 04/21/25 at 2:23 P.M. with Resident #178 revealed he had been waiting for an appointment with the urologist to remove his catheter and would like an update.</p> <p>Observation on 04/22/25 at 8:31 A.M. revealed Resident #178 was seated in his wheelchair and had a breakfast tray in front of him. A catheter bag was noted.</p> <p>Interview on 04/22/25 at 8:50 A.M. with MDS Nurse #513 and MDS Nurse #564 revealed Resident #178's MDS was coded incorrectly because Resident #178 had a catheter. MDS Nurse #513 and #564 stated they thought Resident #178's catheter had been removed upon admission to the facility.</p> <p>Interview on 04/22/25 at 9:48 A.M. with Director of Nursing (DON) and UM #595 confirmed everyone thought Resident #178's catheter had been removed upon admission. The DON stated he saw Resident #178 daily and is not sure how the catheter was missed.</p> <p>52003</p> <p>2. Record review revealed Resident #104 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, traumatic subdural hemorrhage with loss of consciousness, tracheostomy status, and severe protein-calorie malnutrition.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #104's admission Minimum Data Set (MDS) assessment completed on 01/21/25, revealed section L was marked no for broken natural teeth.</p> <p>Interview on 04/21/25 at 1:28 P.M. with Resident #104 revealed the resident reported broken and missing teeth due to a history of drug use.</p> <p>Interview on 04/22/25 at 2:33 P.M. with Certified Nursing Assistant (CNA) #592 confirmed staff provided oral care for Resident #104 and the resident had several missing and broken teeth.</p> <p>Interview on 04/22/25 at 2:38 P.M. with MDS Licensed Practical Nurse (LPN) #564 confirmed the MDS was incorrect and did not address broken or missing teeth.</p> <p>50538</p> <p>3. Review of Resident #86's medical record revealed an admitted [DATE], with a re-admitted [DATE] with diagnoses including transient cerebral ischemic attack, diabetes, asthma, atrial flutter, major depressive disorder, hypertension, hyperlipidemia, and hypothyroidism.</p> <p>Review of Resident #86's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) Score of 15 indicating the resident's cognition was intact.</p> <p>Review of Resident #86's medical record revealed a fall on 04/05/25 at 7:19 P.M. Resident #86 was getting up to go to the bathroom and lost her balance resulting in a bruise on the resident's back. Further review revealed no other falls since the 03/30/25 admission and no other injuries from the 04/05/25 fall.</p> <p>In an interview on 04/23/25 at 2:21 P.M. MDS Licensed Practical Nurse (LPN) #540 verified Resident #86 had not had a fall with major injury since the 03/30/25 admission. MDS LPN #540 confirmed that MDS section J1900 C. falls with major injury should not have been marked as a yes.</p> <p>Review of a policy titled MDS 3.0 dated 01/24/24 revealed it is the policy of the facility to utilize the MDS Resident Assessment Instrument (RAI) manual as the source document for any/all MDS scheduling, encoding, completion, submission, correction, and retention requirements as outlined in chapter two through six of the RAI manual.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</b></p> <p>Based on observation, record review, interview and policy review the facility failed to maintain comprehensive, resident centered care plans. This affected three (#40, #104, and #178) of four residents reviewed for comprehensive care plans. The facility census was 124.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #40 admitted to the facility on [DATE] with diagnoses including malignant neoplasm of unspecified part of unspecified bronchus or lung, chronic obstructive pulmonary disease, and atherosclerotic heart disease without angina.</p> <p>Review of a minimum data set (MDS) dated [DATE] revealed Resident #40's cognition was intact and the resident received injections and antibiotics.</p> <p>Review of an order dated 04/23/25 revealed Resident #40 had a PICC (peripherally inserted central catheter) line in place to be removed after the completion of antibiotic therapy.</p> <p>Review of a care plan dated 03/31/25 revealed Resident #40's comprehensive care plan was not completed related to the type of intravenous access she had for her antibiotics. Resident #40's care plan read, resident has an IV (intravenous) (SPECIFY: Central line, Peripherally inserted central catheter (PICC) line, Midline, Peripheral line) related to: (blank).</p> <p>Interview on 04/23/25 at 1:59 P.M. with the Director of Nursing (DON) confirmed Resident #40's comprehensive care plan was incomplete related to her IV status.</p> <p>2. Record review revealed Resident #178 admitted to the facility on [DATE] with diagnoses including occlusion and stenosis of right carotid artery, peripheral vascular disease, atrial fibrillation, and benign prostatic hyperplasia.</p> <p>Review of a nursing note dated 04/01/25 at 1:00 P.M. by Unit Manager (UM) #595 revealed Resident #178 admitted to the facility with a #16 French (size of the catheter tube) indwelling catheter for urinary retention.</p> <p>Review of a Urinary Continence Evaluation dated 04/08/25 at 4:47 P.M. revealed Resident #178 was always continent and did not have a urinary catheter in use.</p> <p>Review of an admission MDS dated [DATE] revealed Resident #178's cognition remained intact, he did not have an indwelling catheter, and his urinary continence was not rated.</p> <p>Review of a care plan completed on 04/14/25 revealed no evidence of a care plan related to Resident #178's urinary catheter.</p> <p>Review of orders revealed no evidence of orders to care for Resident #178's urinary catheter.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/21/25 at 2:23 P.M. with Resident #178 revealed he had been waiting for an appointment with the urologist to remove his catheter and would like an update.</p> <p>Observation on 04/22/25 at 8:31 A.M. revealed Resident #178 was seated in his wheelchair and had a breakfast tray in front of him. A catheter bag was noted.</p> <p>Interview on 04/22/25 at 8:33 A.M. with UM #595 revealed he does complete some care plans, but the MDS nurses' complete most of the care plans. UM #595 stated upon admission, the floor nurse will enter orders, but the unit managers will assist and complete a clinical review to ensure nothing was missed.</p> <p>Interview on 04/22/25 at 8:50 A.M. with MDS Nurse #513 and MDS Nurse #564 confirmed there was not a care plan in place for catheter. Both MDS Nurse #513 and #564 stated they thought Resident #178's catheter had been removed upon admission to the facility.</p> <p>Interview on 04/22/25 at 9:48 A.M. with the Director of Nursing (DON) and UM #595 confirmed Resident #178 did not have a care plan related to an indwelling catheter. The DON stated in conversations with his staff, everyone thought Resident #178's catheter had been removed upon admission. The DON stated he does see Resident #178 daily and is not sure how the catheter was missed.</p> <p>52003</p> <p>3. Record review revealed Resident #104 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, traumatic subdural hemorrhage with loss of consciousness, nontraumatic intracerebral hemorrhage, tracheostomy status, and severe protein-calorie malnutrition.</p> <p>Interview and observation on 04/21/25 at 1:28 P.M. with Resident #104 revealed the resident had broken and missing teeth due to history of drug use.</p> <p>Review of Resident #104's current plan of care did not address oral/dental status.</p> <p>Interview on 04/22/25 at 2:33 P.M. with Certified Nursing Assistant (CNA) #592 confirmed staff provide oral care for Resident #104 and the resident has several missing and broken teeth but does not complain of pain during care.</p> <p>Interview on 04/22/25 at 2:38 P.M. with MDS Licensed Practical Nurse (LPN) #564 confirmed there was no care plan to address oral/dental status.</p> <p>Review of a policy titled Comprehensive Care Plans dated 06/30/22 revealed the facility is to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be developed within seven days after the completed of the MDS and will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and it will be prepared by the interdisciplinary team.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51519</p> <p>Based on observations, interviews, medical record review and missing items log review, the facility failed to ensure missing hearing aides were reported to the appropriate staff and failed to ensure hearing aides were worn as directed to aide in communication. This affected one (Resident #32) of one resident reviewed for vision/hearing. The census was 124.</p> <p>Findings Include:</p> <p>Record review revealed Resident #32 admitted to the facility 09/04/23 with diagnoses including atrial fibrillation, chronic obstructive pulmonary disease, hyperlipidemia, diastolic heart failure, congestive heart failure, hearing loss.</p> <p>Review of Resident #32 care plan completed 08/16/23 and revised 02/10/24 revealed Resident is at risk for impaired communication related to being hard of hearing. Goals include Resident#32 will understand others when communicating through next review. Interventions include Allow ample time for the resident to comprehend what is being communicated and allow time for response, Audiology referral as needed. Encourage conversations in calm, quiet locations with minimal background noise. Maintain eye contact, approach resident from the front, pay attention to resident's body language and facial expressions, Request feedback, when needed, to ensure understanding, Speech Language Pathology screen / eval / treat as needed. Use simple and direct communication (i.e., yes/no questions) to promote understanding, use gestures or pictures if necessary.</p> <p>Record review of the audiology group note for Resident #32 dated 02/03/25 revealed Resident #32 had profound sensorineural hearing loss of the right eat and severe to profound sensorineural hearing loss of the left ear. Otoscopy revealed the right nor left ear were occluded. Recommendations included bilateral hearing aids, stating Resident #32 decided to try receiver-in-canal (RIC) hearing aids. Recommendations include Resident #32 to wear hearing aids daily, requiring assistance with insertion and manipulation of hearing aid daily. Signed by Certificate of Clinical Competence in Audiology (M.A., CCC-A) #1738 on 02/03/25.</p> <p>Record review of the minimum data set (MDS) completed 02/20/25 section B for hearing speech, and vision revealed Resident #32 has moderate difficulty hearing loss, but does not have hearing aids.</p> <p>Record review revealed a social service progress note dated 03/10/25 revealed Resident #32 answered questions in a low tone and moderate speed. Resident #32 did require social services to repeat questions due to hearing issues.</p> <p>Record review revealed a social services progress note dated 03/24/25 that the resident was seen in house by audiology.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the audiology group note for Resident #32 dated 03/24/25 revealed Resident #32 received right and left hearing aides that fit good. Resident #32 stated she is hearing better with the hearing aids. Consulted as to daily use. Red is for the right ear and blue is for the left ear. Model for right ear hearing aides are BTE/[NAME] laboratories Inc. [NAME] evvolv A1 1000 RIC 312 2025 serial number #250069542. Model for left ear hearing aides are BTE/[NAME] laboratories Inc. [NAME] evvolv A1 1000 RIC 31 2025 serial number #250069553. Signed by M.A., CCC-A #1738 on 03/24/25.</p> <p>Record review revealed no refusal by Resident #32 to wear hearing aids and no evidence hearing aids were missing and not being utilized daily as recommended for Resident #32 to improve communication and understanding.</p> <p>Observation and interview of Resident #32 on 04/24/25 at 9:27 A.M. revealed a hearing aide case sitting on the bedside table. Resident #32 required questions to be repeated and having to raise tone of voice while asking questions so she could hear and understand the conversation. Resident #32 stated she was not wearing hearing aids at this time. She stated one was missing and she didn't know where it was. Resident #32 confirmed it was hard for her to hear and understand what someone was saying due to her hearing loss.</p> <p>Interview on 04/24/25 at 9:55 A.M. with Certified Nursing Assistant (CNA) #598 confirmed one hearing aid was in the box on Resident #32 bedside table and one hearing aid for Resident #32 was missing. Resident #32 stated it had been missing for a while.</p> <p>Interview on 04/24/25 at 11:36 A.M. with CNA #566 confirmed they have not found Resident #32's missing hearing aid and they have looked multiple times today.</p> <p>Interview on 04/24/25 at 11:30 A.M. with Registered Nurse #617 revealed that Resident #32's hearing aids have been missing and confirmed they are still missing at this time. She stated she was unsure who all was aware of this and who had been involved with the missing hearing aids.</p> <p>Interview on 04/24/25 at 11:51 A.M. with social services director #534 stated Resident # 32 did not have hearing aids when she was admitted . The surveyor informed social services that there was a case at Resident #32 bedside with one hearing aide in the case. She stated that the son bought hearing amplifiers at Wal-Mart and that is what those are, and if there is one missing this is the first she has heard about it. Social services director #534 stated she was going to complete a concern form. Social services director #534 confirmed the missing items on the concern log for Resident #32 on 04/09/25 did not include a hearing aid. Social services confirmed, upon review of the audiology note dated 03/24/25, Resident #32 does have bilateral hearing aids from the audiology group.</p> <p>Interview on 04/25/25 at 10:55 A.M. with customer care coordinator #1072 of the Audiology Group confirmed Resident #32 did receive hearing aids dispensed on 03/24/25 and was to wear them daily while requiring assistance to place them. They confirmed thr facily has not reached out to the audiology group regarding a missing hearing aid for Resident #32.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34299</p> <p>Based on observation, interview, medical record review and facility policy review the facility failed to provide a comprehensive treatment plan for altered skin integrity to Resident #48. This affected one resident (Resident #48) of two residents reviewed for non pressure skin conditions. The facility census was 124.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disorder, diabetes mellitus type two, peripheral vascular disease, congestive heart failure and atrial fibrillation.</p> <p>Review of the plan of care revised on 03/11/25 revealed Resident #48 was at risk for skin impairment with interventions in place to decrease risk. The plan of care did not include interventions for bilateral lower extremities discoloration and dry skin.</p> <p>Review of the Medicare five day Minimum Data Set (MDS) dated [DATE] revealed Resident #48 was cognitively intact with no behaviors. Resident #48 was dependent on staff for toileting hygiene, showers, transfers and dressing. Resident #48 had no skin impairment documented.</p> <p>Review of the physician orders dated 04/25 revealed an order for daily skin checks with care by the Certified Nursing Assistants (CNA) and weekly skin assessment by nursing staff.</p> <p>Review of the nursing weekly skin assessment dated [DATE] revealed Resident #48 had redness to bilateral axilla area. No other skin impairment was noted.</p> <p>Observations on 04/21/25 at 1:47 P.M., and 04/23/25 at 11:12 A.M. revealed Resident #48 had his bilateral lower extremities elevated on a pillow. Bilateral lower extremities were dark blue in color, cool to touch and had dry, flaky skin.</p> <p>Interview on 04/23/25 at 11:12 A.M. with Resident #48 revealed he had a bath on 04/22/25. Resident #48 was not sure if the CNA had applied any lotion or ointment to his bilateral lower extremities.</p> <p>Interview on 04/23/25 at 11:14 A.M. with CNA #577 confirmed Resident #48 had dark blue colored bilateral lower extremities with dry, flaky skin.</p> <p>Interview on 04/23/25 at 1:58 P.M. with Licensed Practical Nurse (LPN) # 517 confirmed Resident #48 bilateral lower extremities were discolored and had dry flaky skin. LPN # 517 stated he would document his findings of Resident #48 skin and notify the physician for orders. LPN # 517 also stated he would update the plan of care to include the discoloration, dry, flaky skin to bilateral lower extremities.</p> <p>Review of the facility policy titled Non Pressure Skin revealed skin impairment would be monitored, assessed and treatment provided as ordered.</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  04/25/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50538</p> <p>Based on observation, interview and record review the facility failed to ensure residents received comprehensive and resident centered care related to indwelling urinary catheters. This affected two residents (#28 and #178) of three sampled for catheters. The facility census was 124.</p> <p>Findings include:</p> <p>1. Review of Resident #28's medical record revealed an admitted [DATE], a re-entry date of 05/21/18 and diagnoses including diabetes, anemia, neurogenic bladder, dementia, bipolar disorder, anxiety, attention-deficit hyperactivity disorder, and mild intellectual disabilities.</p> <p>Review of Resident #28's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact, used an indwelling catheter to empty her bladder and had a diagnosis of neurogenic bladder.</p> <p>An observation of Resident #28 on 04/21/25 at 10:45 A.M. revealed the resident to have a catheter and the catheter bag to be hanging on the positioning rail attached to the resident's bed above the resident's bladder.</p> <p>In an interview on 04/21/25 at 10:46 A.M. Licensed Practical Nurse (LPN) #581 verified the catheter bag was positioned above the resident's bladder.</p> <p>An observation of Resident #28 on 04/22/25 at 10:52 A.M. revealed her catheter bag to be positioned on the floor.</p> <p>In an interview on 04/22/25 at 10:55 A.M. Registered Nurse (RN) #536 confirmed the catheter bag was positioned on the floor.</p> <p>Review of the policy titled Catheter Care - Urinary dated 10/30/20 and revised 12/28/23 revealed the facility was to provide catheter care to all residents in a manner to reduce bladder and kidney infections. Further review revealed catheter were to be maintained to gravity drainage.</p> <p>47985</p> <p>2. Record review revealed Resident #178 admitted to the facility on [DATE] with diagnoses including occlusion and stenosis of right carotid artery, peripheral vascular disease, atrial fibrillation, and benign prostatic hyperplasia.</p> <p>Review of a nursing note dated 04/01/25 at 1:00 P.M. by Unit Manager (UM) #595 revealed Resident #178 admitted to the facility with a #16 French (size of catheter) indwelling catheter for urinary retention.</p> <p>Review of a Urinary Continence Evaluation dated 04/08/25 at 4:47 P.M. revealed Resident #178 was always continent and did not have a urinary catheter in use.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an admission MDS dated [DATE] revealed Resident #178's cognition remained intact, he did not have an indwelling catheter, and his urinary continence was not rated.</p> <p>Review of a care plan completed on 04/14/25 revealed no evidence of care planning related to Resident #178's urinary catheter.</p> <p>Review of orders revealed no evidence of orders to care for Resident #178's urinary catheter.</p> <p>Interview on 04/21/25 at 2:23 P.M. with Resident #178 revealed he had been waiting for an appointment with the urologist to remove his catheter and would like an update.</p> <p>Observation on 04/22/25 at 8:31 A.M. revealed Resident #178 was seated in his wheelchair and had a breakfast tray in front of him. A catheter bag was noted.</p> <p>Interview on 04/22/25 at 8:50 A.M. with MDS Nurse #513 and MDS Nurse #564 revealed Resident #178's MDS was coded incorrectly because Resident #178 had a catheter, they confirmed there was not a care plan in place for catheter, and there were no orders since admission for Resident #178 to have an indwelling catheter or catheter care. Both MDS Nurse #513 and #564 stated they thought Resident #178's catheter had been removed upon admission to the facility.</p> <p>Interview on 04/22/25 at 9:48 A.M. with the Director of Nursing (DON) and UM #595 confirmed Resident #178 did not have orders, a care plan, or an accurate assessment related to the resident's indwelling urinary catheter. The DON stated in conversations with his staff, everyone thought Resident #178's catheter had been removed upon admission. The DON stated he does see Resident #178 daily and is not sure how the catheter was missed.</p> <p>Review of a policy titled Catheter Care Procedure - Urinary dated 12/28/23 revealed the facility is to provide catheter care to all residents that have an indwelling catheter in an effort to reduce bladder and kidney infections while maintaining their dignity and privacy. Residents with indwelling urinary catheters will be provided catheter care in accordance with current clinical standards including each shift, with each bowel movement, as needed and as requested.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52003</p> <p>Based on record review, interview and policy review the facility failed to ensure nursing staff planned to administer the appropriate dose of medication, without resident intervention, to prevent a potential overdose. This affected one resident (Resident #104) of one residents reviewed for a medication error. The census was 124.</p> <p>Findings Include:</p> <p>Record review revealed Resident #104 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, traumatic subdural hemorrhage with loss of consciousness, nontraumatic intracerebral hemorrhage, pneumonitis due to inhalation of food and vomit, and tracheostomy status.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #104 had a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Record review revealed on 12/24/24 an order was received for Methadone 10 milligrams (mg): Give two tablets by mouth three times a day However the order was discontinued on 12/24/24. On 12/26/24, an order for Methadone 10 mg give two tablets via nasogastric (NG) tube three times a day however the order was discontinued on 12/26/24. On 12/26/24, an order was received for Methadone HCl Oral Tablet 10 mg give two tablet by mouth three times a day however the order was discontinued on 12/26/24. On 12/31/24 an order for Methadone liquid dated 12/31/24 for 60 mg/7.5 milliliters (ml) by mouth each morning one time a day.</p> <p>Further review of the medical record revealed a medication error which occurred on 12/31/24 for Methadone. Resident #104 was given 30 ml (four of the 7.5 ml bottles) instead of 7.5 ml (one bottle). The possible medication error was not found until the next day 01/01/25 when the morning dose was scheduled to be administered.</p> <p>Review of the medication administration record (MAR) dated 12/31/24 at 8:00 A.M. revealed the nurse documented administration of one Methadone 7.5 ml bottle. The narcotic sheet had four of the 7.5 ml bottles signed out for administration.</p> <p>Review of facility investigation dated 01/01/25, during narcotic count staff nurses found a narcotic discrepancy with the Methadone. The night shift nurse stated they were in a hurry, and they did not unlock the methadone case during the 12/31/24 7:00 P.M. count during sign off. It was discovered the dayshift nurse administered extra bottles of Methadone. On 01/01/25 the medication error was reported to the unit manager, Director of Nursing (DON) and the medical director.</p> <p>Interview on 04/24/25 at 9:13 A.M. with the the Regional Director of Clinical Operations, confirmed the prescription for Methadone was not entered correctly in the computer due to the supply amount from the pharmacy and the nurse thought the resident was to receive four bottles of Methadone instead of one bottle.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/25 at 9:34 A.M. with the Regional Director of Clinical Operations revealed the first four orders of methadone were what the hospital ordered however were unable to fill the prescription due to the resident's diagnosis and the resident required a referral to a methadone clinic. Oxycodone was ordered until the Methadone was available for the resident. The appointment at the Methadone clinic was on 12/26/24 and they supplied 27 days worth of Methadone (27 bottles). The order was initially transcribed incorrectly and the nurse thought the order meant to administer four bottles and not one to get the ordered dose. When the nurse went to clarify the order, the DON did correct the order in the system however the order entered was set to start the following day and did not appear on the MAR at the time of administration, so the nurse prepared the incorrect dose. The Regional Director of Clinical Operations said the resident only received one dose of the methadone because the resident stopped the nurse and refused to take the additional medication, knowing what the ordered dose was.</p> <p>Interview on 04/24/25 at 4:58 P.M. with Licensed Practical Nurse (LPN) #569 via telephone confirmed she prepared the incorrect dose of Methadone for administration.</p> <p>Review of facility policy titled Medication reconciliation dated reviewed/ revised: 01/30/24 states medication reconciliation refers to the process of verifying that the residents current medication list matches the physicians orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52003</p> <p>Based on record review, staff interview and policy review, the facility failed to thoroughly investigate a potential medication error and the disposition of controlled medications. This affected one resident (#104) of one residents reviewed for a medication error. The facility census was 124.</p> <p>Findings Include:</p> <p>Record review revealed Resident #104 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, traumatic subdural hemorrhage with loss of consciousness, nontraumatic intracerebral hemorrhage, pneumonitis due to inhalation of food and vomit, and tracheostomy status.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #104 had a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Record review revealed on 12/24/24 an order was received for Methadone 10 milligrams (mg): Give two tablets by mouth three times a day However the order was discontinued on 12/24/24. On 12/26/24, an order for Methadone 10 mg give two tablets via nasogastric (NG) tube three times a day however the order was discontinued on 12/26/24. On 12/26/24, an order was received for Methadone HCl Oral Tablet 10 mg give two tablet by mouth three times a day however the order was discontinued on 12/26/24. On 12/31/24 an order for Methadone liquid dated 12/31/24 for 60 mg/7.5 milliliters (ml) by mouth each morning one time a day.</p> <p>Further review of the medical record revealed a medication error which occurred on 12/31/24 for Methadone. Resident #104 was given 30 ml (four of the 7.5 ml bottles) instead of 7.5 ml (one bottle). The possible medication error was not found until the next day 01/01/25 when the morning dose was scheduled to be administered.</p> <p>Review of the medication administration record (MAR) dated 12/31/24 at 8:00 A.M. revealed the nurse documented administration of one Methadone 7.5 ml bottle. The narcotic sheet had four of the 7.5 ml bottles signed out for administration. There was no documentation of the wasted Methadone.</p> <p>Review of facility investigation dated 01/01/25, during narcotic count staff nurses found a narcotic discrepancy with the Methadone. The night shift nurse stated they were in a hurry, and they did not unlock the methadone case during the 12/31/24 7:00 P.M. count during sign off. It was discovered the dayshift nurse administered extra bottles of Methadone. On 01/01/25 the medication error was reported to the unit manager, Director of Nursing (DON) and the medical director.</p> <p>Interview on 04/24/25 at 9:13 A.M. with the Regional Director of Clinical Operations, confirmed the prescription for Methadone was not entered correctly in the computer due to the supply amount from the pharmacy and the nurse thought the resident was to receive four bottles of Methadone instead of one bottle.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/25 at 9:34 A.M. with the Regional Director of Clinical Operations revealed the first four orders of methadone were what the hospital ordered however were unable to fill the prescription due to the resident's diagnosis and the resident required a referral to a methadone clinic. Oxycodone was ordered until the Methadone was available for the resident. The appointment at the Methadone clinic was on 12/26/24 and they supplied 27 days worth of Methadone (27 bottles). The order was initially transcribed incorrectly and the nurse thought the order meant to administer four bottles and not one to get the ordered dose. When the nurse went to clarify the order, the DON did correct the order in the system however the order entered was set to start the following day and did not appear on the MAR at the time of administration, so the nurse prepared the incorrect dose. The Regional Director of Clinical Operations said the resident only received one dose of the methadone because the resident stopped the nurse and refused to take the additional medication, knowing what the ordered dose was.</p> <p>Interview on 04/24/25 at 04:28 P.M. with the Regional Director of Clinical Operations confirmed the narcotic count was not completed correctly to identify the potential medication error timely (shift to shift count) and confirmed the narcotic log/waste was not completed to identify the second nurse who witnessed the medication waste. The Regional Director also confirmed the investigation did not identify the lack of a second nurse documented as witnessing the disposition of the Methadone not used. LPN #569 was contacted but she could not remember who the second nurse was when the medication was wasted.</p> <p>Interview on 04/24/25 at 4:58 P.M. with Licensed Practical Nurse (LPN) #569 via telephone confirmed she prepared the incorrect dose of Methadone for administration and she flushed the remaining medication in the toilet.</p> <p>Review of facility policy titled Medication-Destruction of Unused Drugs Date Reviewed/Revised: 01/18/24 states prescription drugs shall not be flushed down the toilet in accordance with Environmental Protection Agency regulations. Scheduled II, III, and IV controlled drugs must be destroyed by the Director of Nursing Services and another Licensed Nurse.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 07316</p> <p>Based on review of facility alternative dispute resolution agreements, interview, record review, and policy review, the facility failed to ensure residents understood the agreement they signed. This affected three of three residents reviewed for arbitration agreements (Residents #31, #89, and #178). The facility census was 124.</p> <p>Findings include:</p> <p>1. Review of the record for Resident #31 revealed an admitted [DATE]. Review of a Minimum Data Set (MDS) assessment completed 01/27/25 and 03/06/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.</p> <p>Review of a facility Alternative Dispute Resolution Agreement dated 01/20/25 revealed Resident #31 electronically signed the agreement on 01/23/25. The agreement stated it demonstrated a mutual intention to resolve disputes between them outside of court and to submit their disputes to Alternative Dispute Resolution through mediation and/or arbitration. The form also stated that the resident had been offered to, or had been able to view an audio/visual recorded video that details this agreement and what it includes.</p> <p>Interview with Resident #31 on 04/24/25 at 9:40 A.M. revealed she did not remember signing the agreement. She also stated she did not watch a video explaining the agreement. She stated she did not understand what the agreement was for.</p> <p>2. Review of the record for Resident #89 revealed an admitted [DATE]. Review of a MDS assessment completed 6/13/24 and 02/26/25 revealed a BIMS score of 15, indicating intact cognition.</p> <p>Review of a facility Alternative Dispute Resolution Agreement dated 6/05/24 revealed Resident #89 electronically signed the agreement on 6/14/24. The agreement stated it demonstrated a mutual intention to resolve disputes between them outside of court and to submit their disputes to Alternative Dispute Resolution through mediation and/or arbitration. The form also stated that the resident had been offered to, or have been able to view an audio/visual recorded video that details this agreement and what it includes.</p> <p>Interview with Resident #89 on 04/24/25 at 9:55 A.M. revealed she did not remember signing the dispute resolution agreement. She stated she did not remember doing her electronic signature on an iPad. She stated she was not offered to watch a video explaining the agreement and did not understand what the agreement was.</p> <p>3. Review of the record for Resident #178 revealed an admitted [DATE]. Review of a MDS assessment completed 04/08/25 revealed a BIMS score of 15, indicating intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility Alternative Dispute Resolution Agreement dated 04/01/25 revealed Resident #178 electronically signed the agreement on 04/04/25. The agreement stated it demonstrated a mutual intention to resolve disputes between them outside of court and to submit their disputes to Alternative Dispute Resolution through mediation and/or arbitration. The form also stated that the resident had been offered to, or have been able to view an audio/visual recorded video that details this agreement and what it includes.</p> <p>Interview with Resident #178 on 04/24/25 at 9:30 A.M. revealed he did not remember signing the agreement electronically on an iPad. He stated the agreement was not explained to him and he did not watch a video explaining the agreement. He stated he would not have signed the agreement had he known what it was. He stated he wanted to revoke the agreement.</p> <p>Interview with Admissions Director #599 on 04/24/25 at 10:05 A.M. revealed the agreement is part of the facility admission packet. She stated residents are told it is optional and they are offered a video to watch that explains the arbitration agreement. She stated residents are asked to sign the agreement electronically on an iPad. She stated it is usually just her and the resident in the room at the time (no witness).</p> <p>Review of the facility policy titled Binding Arbitration Agreements dated 07/28/20 and revised 11/01/22 revealed this facility asks all residents to enter into an agreement for binding arbitration. The facility shall explain to the resident or his or her representative in a form and manner that he or she understands.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538</b></p> <p>Based on observation, interview and record review the facility failed to complete appropriate hand hygiene during medication administration and to maintain contact isolation precautions while in a resident's room with clostridium difficile. This affected two residents (#104 and #178) of five sampled for infection control. The facility census was 124.</p> <p>Findings include:</p> <p>1. Review of Resident #104's medical record revealed an admitted [DATE] and diagnoses including acute respiratory failure with hypoxia, traumatic subdural hemorrhage, chronic pancreatitis, anemia, pneumonitis due to inhalation of food or vomit, tracheostomy status, and gastrostomy status.</p> <p>Review of Resident #104's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15. Further review revealed the resident was receiving enteral feedings via a gastrostomy tube.</p> <p>Review of Resident #104's orders revealed an order for the resident to be on enhanced barrier precautions (due to the gastrostomy tube, considered an indwelling medical device).</p> <p>An observation on 04/23/25 at 8:20 A.M. of medication administration by Licensed Practical Nurse (LPN) #628 revealed LPN #628 administered Resident #104's medications via his gastrostomy tube and then changed her gloves to administer his nasal inhaler. LPN #628 did not complete hand hygiene when she changed her gloves and then preceded to administer the nasal inhaler.</p> <p>On 04/23/25 at 8:25 A.M. LPN #628 confirmed she did not complete hand hygiene when she changed her gloves prior to administering Resident #104's nasal inhaler.</p> <p>Review of the policy titled Flushing the Feeding Tube dated 01/01/21 and revised 06/30/22 revealed facility staff should wash their hands after administrating medications via the feeding tube.</p> <p>52003</p> <p>2. Review of Resident #178's medical record revealed an admitted [DATE] with diagnoses that included essential hypertension, peripheral vascular disease and contact with and suspected exposure to COVID-19.</p> <p>Physician's orders indicated Resident #178 required contact transmission-based precautions for c-diff (inflammation of the colon caused by the bacteria Clostridium difficile).</p> <p>Observation on 04/24/25 at 12:34 P.M. revealed Certified Nursing Assistant (CNA) # 531 entering Resident #178's room to deliver lunch tray. A sign was posted outside of the room door to Resident #178's room indicating he was on contact precautions and a cart containing personal protective supplies was noted below the sign and outside the resident's room door.</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  04/25/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/25 at 12:35 P.M. with CNA #531 verified the resident had contact precautions in place for C-Diff and she did not wear appropriate personal protective equipment (PPE) while she was in the resident's room.</p> <p>Review of facility policy titled Infection Prevention and Control Program: A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current Center for Disease Control guidelines.</p>		