STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review and interview, the facility failed to complete an accurate comprehensive assessment. This affected one resident (#3) of three residents sampled. The census was 49.Closed medical record review revealed Resident #3 was admitted on [DATE] with diagnoses including Alzheimer's disease, schizoaffective disorder and intermittent explosive disorder.Review of the Physician Progress Note dated 04/15/25 revealed Resident #3 was being evaluated for his dementia. The facility gave the patient and family a 30-day notice that the secured unit was closing. The resident was not suitable for the main floor and was at high-risk for elopement, had a history of aggressive behaviors and agitation. He had a brief time out on the main floor and things did not go well. He was at high risk for elopement, aggression and needs close supervision and a secure unit to protect him and others. Family provided facility she would like referred to. Staff to make the referral.Review of the Notice of Transfer or discharge date d 04/18/25 revealed Resident #3 was to discharge on [DATE] due to the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility.Review of Resident #3's Discharge-return not anticipated Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed an unplanned discharge to another long-term care facility on 04/21/25.On 07/23/25 at 11:22 A.M. and 1:29 P.M., interview with Registered Nurse (RN) #102 and Social Service Designee #108 revealed the following: RN #102 stated she coded the MDS assessment as unplanned because the resident had originally planned to discharge on [DATE] but did not discharge until 04/21/25. SSD #108 stated the reason for the delay in discharge was the family had to get a truck to move the resident's personal items from the facility. RN #102 stated because it was a day later than the originally scheduled discharge, it was then considered unplanned. RN #102 stated if a discharge was set for a certain date and time, and it deviated from that date/time, she coded it as an unplanned discharge. SSD #108 and RN #102 verified the resident was provided a 30-day notice regarding the closure of the facility secured unit and had to discharge due to he required placement on a secured unit. RN #102 declined to verify the above. Review of the Centers for Medicare and Medicaid Website defined (for the MDS Assessment) an unplanned discharge as a discharge to an acute care hospital or an emergency department in order to either stabilize a condition or determine if an acute care admission is required based on the emergency department evaluation, leaving the facility against medical advice, unexpectedly deciding to go home or to another setting. A planned discharge indicates that the resident's departure from the facility is anticipated and scheduled.This is an incidental finding discovered during the complaint investigation.

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