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	09/15/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a resident, who was dependent on staff for personal care, was provided the assistance needed to complete bathing activities of her choice when scheduled, and nail care was provided when needed. This affected one (Resident #7) of four residents reviewed for activities of daily living (ADL's). The facility census was 48. Findings include: Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included rheumatoid arthritis, osteoarthritis, difficulty walking, and adult-onset diabetes mellitus. Review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues. Her cognition was moderately impaired. She was not known to have displayed any behaviors or reject care during the seven day assessment period (06/20/25- 06/26/25). She required partial/ moderate assistance with showers/ bathing and required set up or clean-up assistance for personal hygiene. Review of Resident #7's active care plans revealed she had a care plan in place for the resident to be at risk for ADL/ mobility decline and required assistance related to limited mobility, rheumatoid arthritis, and polyarthritis. The care plan was initiated on 04/02/25. The goal was for the resident to have her needs anticipated and met by staff. The interventions included encouraging the resident to participate in ADL's to promote independence, provide hand hygiene and nail care per the resident's preference, and to provide showers and/ or bed baths per the resident's preference. There was nothing in her active care plans that indicated she was non-compliant or known to refuse personal care services to include bathing and nail care. Review of Resident #7's care record that was part of her electronic medical record (EMR) revealed the resident's shower days were Wednesdays and Saturdays. Her bathing activity was to occur on the day shift. Review of Resident #7's shower documentation under the task tab of the EMR revealed the resident's last documented shower was on 08/23/25. Nail care was indicated to have been provided on that date as part of her bathing activity. She was indicated to have refused her shower when offered on 08/27/25 (Wednesday). There was no indication of her being offered a shower/ bath on 08/30/25 (Saturday), which was the last day she was scheduled to receive one. On 09/02/2025 at 1:03 P.M, an observation of Resident #7 noted her to be lying in bed. She was noted to have a dark substance under her fingernails on some of her fingers. On at 09/03/2025 at 10:16 A.M., further observation of Resident #7 noted her to be in bed. Her fingernails continued to have a dark colored substance under the ends of her fingernails. An interview with the resident at the time of the observation revealed she did not recall staff offering her a shower on 08/30/25 (Saturday), the last day she was scheduled to receive one. On 09/03/25 at 10:19 A.M. an interview with RN #200 revealed all showers/ baths were documented in the computer. She denied the facility used any paper shower sheets for the documentation of showers. On 09/03/25 at 10:30 A.M., an interview with the Director of Nursing (DON) confirmed Resident #7's scheduled shower days were on Wednesdays and Saturdays and were to be completed on day shift. She verified the resident's last documented shower was provided on 08/23/25, in which nail care was provided. The resident was indicated to have refused her shower on 08/27/25, when offered. She further confirmed there was no documentation to support the resident had been offered or provided a shower on 08/30/25 (her most recent scheduled shower day). She acknowledged the resident had been observed yesterday and again today to have a dark colored substance under her fingernails. On 09/03/25 at 11:17 A.M., an interview with Certified Nursing Assistant (CNA) #146 revealed she was just in Resident #7's room and provided her a bed bath. She indicated the resident preferred bed baths, as opposed to showers. She was asked what she did as part of that bathing activity. She reported she washed the resident's hair and also did nail care. She confirmed the resident's fingernails were dirty underneath the end of the nails. She stated that was why she cleaned them. She denied she worked last Saturday to be able to say why there was no documentation of the resident being given her scheduled complete bed bath. She reported the resident was an extensive assist of one for bathing and personal hygiene care. She denied the resident was able to perform her own nail care and was dependent on the staff to do it. This deficiency represents non-compliance investigated under Complaint Intake Number 259304.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff schedule review, facility assessment review, resident council meeting minute review, resident interview and staff interview, the facility failed to provide sufficient staffing to meet the needs of residents in a timely manner. This had the potential to affect all 48 residents residing within the facility. The facility census was 48. Findings Include: Review of the Facility assessment dated [DATE] revealed the assessment will inform the facility's staffing decisions to ensure there are a sufficient number of staff with appropriate competencies necessary to care for residents' needs as identified through resident assessments and plans of care. The facility will consider staffing needs for each resident unit in the facility for each shift and adjust a necessary based on resident population. The facility's contingency plan includes processed to ensure that staffing needs are addressed as they arise. In an unplanned staffing need, the facility uses on-call nurse management to either fill the shift or find appropriate replacement through the utilization of staff call sheets to ensure all facility staff are contacted. This facility assessment was provided by Operational Support #164 on 09/03/24. Review of the Resident Council Meeting Minutes dated 04/21/25 revealed residents voiced concerns that it took too long to answer call light and find additional help if needed on the weekends. Residents also stated they had a hard time finding someone to take them out to smoke. Review of the Meeting Minutes dated 05/19/25 revealed all old business issues had been resolved; however, there was no evidence the staffing concerns voiced related to staffing were address or call light audits completed. Review of the Resident Council Meeting Minutes dated 08/18/25 revealed residents voiced concerned about how long it takes to get a second set of hands to have the hoyer (mechanical lift) used. On 09/03/25 at 10:52 A.M. during the Resident Council Meeting, six residents (#5, #11, #16, #17, #31 and #32) were in attendance and stated residents had to wait for the mechanical hoyer lift but the nursing staff was doing the best they could, with what they had. Residents stated there was one aide for two halls the other day, smoking was pretty rare as there was not a lot of people available to take you out especially on the weekends. Review of the undated Nursing Staff Ladder for 24 hour period revealed total number of nursing staff for a census of 48 residents was three aides on days, three aides on nights and 5.33 total number of floor nurses. Review of the Staffing Schedules dated 06/30/25 to 07/06/25 revealed there were two Certified Nurse Aides (CNA) for eight hours and one CNA for three hours that worked between 7:00 A.M. and 3:00 P.M. on 07/03/25. The resident census was 48. On 09/02/25 at 9:20 A.M. phone interview with the local Ombudsman was completed. The Ombudsman shared they were aware of staffing concerns in the facility that had previously been brought to their attention that they were currently following up with during their onsite visits at the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/02/25 at 10:07 A.M., interview with Resident #49 stated the call light takes a minimum of 30 minutes to answer, they will have only one aide per hall and so residents cannot go to dining room for meals. Resident smoke breaks are late or no aide with you. On 09/02/25 at 10:39 A.M., interview with a resident who wishes to remain anonymous stated there was not enough staff to get her complete bed baths when scheduled and it takes up to 30 minutes for call lights to get answered. On 09/02/25 at 11:22 A.M., interview with a resident who wishes to remain anonymous stated sometimes have to wait a long time for call light to be answered (30 minutes). The resident was not provided the assistance needed to complete bathing activities of her choice when scheduled on 08/30/35 and nail care was not provided when needed during the course of the biannual survey. On 09/02/25 at 1:26 P.M., interview with a resident who wishes to remain anonymous stated staffing was low on the weekends related to call-offs and has had to wait 30-60 minutes for call light response. On 09/02/25 at 3:14 P.M., interview with a resident who wishes to remain anonymous stated the facility needs more aides so they can be better cared for. The resident stated there were only two nurses and two aides on the weekend. On 09/03/25 at 3:42 P.M., interview with CNA #153 stated she did not think there was enough staff because a lot of the residents require two assist and it's hard to find someone to help you. I always stay over to get my workload done. I can't say I do two hours checks because I don't. I do try, but there's too much to do. On 09/04/25 between 6:50 A.M. and 6:58 A.M., interview with Licensed Practical Nurse (LPN) #126 stated do not always work with a full staff of aides to manage all three halls. When there is a call-off, if agency doesn't pick up the shift, they tell us to use the staff they have to 'make it work'. Resident showers, as well as, check and change every two hours do not always get done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/04/25 at 7:08 A.M., interview with Anonymous Employee #138 who wishes to remain anonymous revealed call lights can take longer than 30 minutes at times to be answered. There are currently no restorative or toileting programs being implemented and when there are only two aides on nights, resident's are not getting their showers because doing their best trying to make rounds to get everyone toileted and changed a couple times through the night. Turning and repositioning is done when they get to change the residents and there are a lot of two-assist dependent residents to care for. All nurses do not help and when their are call-offs management doesn't always come in when called and they tell them to do the best they can. Showers don't get done and it's not fair to the residents but the facility can't keep staff. If a resident gets sick or having a bad night, they take priority over showers and other care needs and once they are okay, they just keep going to get everyone looked at. Stated it is better than it was but care is compromised when only have two aides for the entire building. On 09/04/25 between 7:15 A.M., interview with an Anonymous Employee #147 stated weekends have just two aides during the night shift and that makes it really hard and cannot get scheduled resident showers done. Try to pass ice at beginning of shift and do a quick check on everyone because the rest of the time you are busy doing check and changes, once you get done with your first round, you are already late getting to the residents who were changed first. Do the best they can. On 09/09/25 at 3:07 P.M., interview with LPN #104 states facility uses agency when needed to help maintain adequate staffing. LPN #104 feels currently there is enough staff with management help on the day shift. On 09/04/25 between 6:34 A.M. and 6:45 A.M., interview with LPN #120 stated the staffing levels have improved and use agency staff when needed. LPN #120 stated the staffing has improved over the last several weeks but weekends continue to be a struggle and residents have to wait for care. On 09/08/25 at 1:40 P.M., interview with CNA #129 stated residents cannot smoke without staff and sometimes there just isn't enough time to get it all done and take them to smoke. There have been times when there just wasn't enough staff to take the residents who wanted to smoke at the scheduled times due to resident care that had to be provided to another resident. On 09/09/25 at 10:06 A.M., interview with Central Supply (CS) #100 stated stated she was also the staffing coordinator and both temporary and contractual staff were being used. CS #100 stated it was the expectation if call offs were unable to be covered by facility staff or temporary staff, the nurse management on-call staff would come in to cover the shift. This deficiency represents non-compliance investigated under Complaint Intake Number 259304.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, dietary card review, policy review and interview, the facility failed to serve food to meet the resident needs. This affected one resident (#9) of four residents sampled for nutrition. The census was 48. Findings Include: Medical record review revealed Resident #9 was admitted on [DATE] with diagnoses including dysphagia, oropharyngeal phase. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #9 was moderately impaired for daily decision-making, received a therapeutic and mechanically altered diet, and was edentulous.Review of the care plan: At Potential Risk of Nutritional Decline related to the resident's need for a mechanically altered diet revised 07/17/25 revealed interventions included to provide her diet and supplement per dietitian recommendation and physician order. Review of the electronic Clinical Physician Orders dated September 2025 revealed Resident #9 was ordered a regular diet, soft and bite-sized textures and thin consistency liquids. Review of the Dinner Tray Card dated 09/03/25 dinner meal revealed the resident diet was regular with soft and bite-size texture.On 09/03/25 at 5:13 P.M. , observation of the dinner meal revealed Resident #9 was served her meal as she was seated in a straight back chair in her room in front of an overbed table with her back towards the doorway to her room. The resident meal tray could not be completely viewed at the time of the observation. On 09/03/25 at 5:17 P.M., observation of the residents meal tray in her room revealed a hot dog on a bun, baked beans, a scoop of boiled potatoes, a bowl of diced apples, eight ounce glass of fruit punch and a styrofoam cup of hot chocolate. The hot dog was cut into five uneven pieces ranging from 0.5 inch to 1. 0 inch in length. There were no condiments on the hot dog and the bun extended beyond the meat of the hot dog. No staff was observed in the room with the resident. On 09/03/25 at 5:19 P.M., observation with Licensed Practical Nurse (LPN) #120 verified Resident #9 was holding the last cut piece of one-inch hot dog on a bun in her right hand as she was chewing another bite of hot dog and bun in her mouth. LPN #120 asked the resident about the hot dog and she stated she was fine as she put the last one-inch piece of hot dog with bun into her mouth. The resident was edentulous. LPN #120 verified she was the resident's nurse but was not sure what diet she was on. After reviewing the diet card on the resident's meal tray, LPN #120 verified the resident was to receive soft, bite-sized textured foods. LPN #120 verified a hot dog cut into 1/2 to one-inch pieces would not be considered soft, bite-sized textured foods. On 09/11/25 between 10:29 A.M. and 10:47 A.M., phone interview with Registered Dietitian #203 verified a hot dog was not considered to be part of a soft diet and the hot dog on a bun in 1/2 inch to one inch pieces would not be considered to be bite-sized. The facility stated they did not have a policy for review that defined a soft diet with bite-sized texture.This deficiency represents non-compliance investigated under Complaint Number 2593047.