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	12/04/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to ensure all residents were provided with a dignified dining experience. This affected one (#50) of five residents reviewed for meals. The facility census was 53. Findings include:Record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including type II diabetes, muscle weakness, and cognitive communication deficit. Review of the care plan last reviewed on 09/14/25 revealed no concerns with Resident #50's behaviors related to use of urinals. Review of a minimum data set (MDS) assessment dated [DATE] revealed Resident #50's cognition remained intact, he declined care one to three days of the review period, he required supervision/touching assistance with toileting transfers, and required set-up/clean up help with personal hygiene. Review of a late entry note dated11/24/25 entered for 9:00 A.M. by Staffing Coordinator (SC) #142 stated attempted to enter residents' room and resident expressed agitation and did not want staff present in his room at this time. Interview and observation on 11/24/25 at 11:49 A.M. revealed Resident #50 was sitting at edge of bed in his room eating his lunch. On the footboard of the bed, there were three full urinals hanging by the handle. Resident #50 stated staff will enter his room to bring him his food or pick up his tray or administer medications and but not do anything with the urinals. Resident #50 stated he did not like the urinals to be full and hanging on his bed when he was having his lunch. Interview on 11/24/25 at 11:51 A.M. the Administrator confirmed there were three full urinals hanging on the end of Resident #50's bed while he was having lunch. Review of a nursing note dated 11/24/25 at 1:00 P.M. by SC #142 revealed she entered Resident #50's room and emptied his urinals. Review of a late entry nursing note dated 11/24/25 at 3:42 P.M. for 12:41 P.M. by Licensed Practical Nurse (LPN) #174 revealed Resident #50 had requested staff to stay out of his room this morning. Review of a policy titled Resident Rights dated 08/2009 revealed residents have the right to be treated with respect, kindness, and dignity. This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number 2673793.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to notify the resident and the resident's primary care physician of a medication error. This affected one resident (#50) of three residents reviewed for medication errors. The facility census was 53.Findings Include:Review of the medical record for Resident #50 revealed an initial admission date of 08/27/25 with the diagnoses including but not limited to diabetes mellitus (DM), chronic obstructive pulmonary disease, asthma, hypertension, chronic kidney disease, polyneuropathy, intervertebral disc degeneration, lumbar region, severe morbid obesity, osteoarthritis and obstructive sleep apnea. Review of the plan of care dated 08/27/25 revealed the resident experienced acute and chronic pain or discomfort due to osteoarthritis, neuropathies, wounds, left below the knee amputation, DM, morbid obesity and degenerative disc disease. Interventions included administer medications as ordered, assess for non-verbal indicators of pain, assess pain every shift and as indicated and notify physician if resident experiences unmanageable or intolerable pain. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident utilized scheduled, as needed and non-pharmacological interventions for pain relief. Review of the resident's monthly physician orders for November 2025 identified orders dated 10/30/25 for Oxycodone extended release (ER) 10 milligrams (mg) by mouth every 12 hours for moderate to severe pain and Oxycodone 5 mg by mouth every 12 hours as needed for the pain scale of five to 10. Review of the resident's November 2025 Medication Administration Record (MAR) revealed on 11/04/25 at 8:30 A.M., the nurse initialed the resident was administered Oxycodone 10 mg by mouth as physician ordered. Further review revealed the nurse had not documented the resident received the as needed dose of Oxycodone 5 mg by mouth on 11/04/25 at 8:30 A.M. Review of the resident's controlled drug receipt/record disposition form for the resident's Oxycodone 5 mg by mouth revealed the resident received Oxycodone 5 mg by mouth on 11/05/25 at 7:30 P.M., 11/14/25 at 8:00 A.M., 11/15/25 at 8:00 A.M. and 8:50 P.M. Further review revealed no evidence that the Oxycodone 5 mg by mouth was administered as the as needed dosage. Review of the incident report dated 11/14/25 at 7:34 P.M. revealed during the shift change narcotic sheet counts on 11/14/25 it was discovered the nurse administered Oxycodone 5 mg by mouth instead of the Oxycodone 10 mg by mouth as physician ordered at 8:30 A.M. Review of the medical record revealed no documented evidence the resident or the resident's physician was notified of the medication error of the resident received the wrong dose of medication Oxycodone on the listed dates and the resident should have received Oxycodone 10 mg by mouth. On 11/20/25 at 3:00 P.M., interview with the Regional Nurse #510 verified the facility had no documented evidence the resident or the resident's physician was notified of the medication error. Review of the facility policy titled, Change in a Resident's Condition or Status, last revised in 02/21 revealed the facility would promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status. This deficiency represents incidental finding of non-compliance investigated under Master Complaint Number 2673793.

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, review of fall investigations, review of Quality Assurance (QA) documentation, Mayo Clinic Diabetic Ketoacidosis information review, review of hospital notes, and interviews, the facility failed to comprehensively assess and timely identify an acute change in Resident #22's condition resulting in hospitalization and failed to ensure effective and necessary care and treatment was provided to manage the resident's diabetes mellitus. This affected one resident (#22) of four residents reviewed for change in condition. The facility census was 53. Actual harm occurred beginning on 11/02/25 when Resident #22 was noted at multiple times on this date to have a blood sugar that read hi (a hi reading is reached when the blood sugar result is too high for the glucometer to read, often greater than 600 milligrams per deciliter (mg/dL)) on the glucometer without effective and/or adequate monitoring and treatment. On 11/03/25 Resident #22 did not receive her diabetic medication (blood sugar lowering medications), insulin glargine (a long acting human insulin use to manage blood glucose levels in individuals with type 1 and type 2 diabetes) or Novolog insulin (a rapid acting insulin used to manage blood sugar levels in individuals with type 1 and type 2 diabetes) at (if needed based on blood sugar results) at 9:00 A.M. as scheduled. Resident #22 was later found (on this date) in her room unresponsive on the floor with a hi blood sugar glucometer reading. Resident #22 was transferred to the hospital and admitted to the intensive care unit (ICU) for treatment of diabetic ketoacidosis (a life-threatening medical emergency that occurs when the body, lacking sufficient insulin, breaks down fat for energy, creating high levels of ketones that make the blood acidic) and sepsis (a life-threatening medical emergency where the body's response to an infection triggers a chain reaction that causes tissue damage and organ dysfunction). Findings include:Review of Resident #22's closed medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including type I diabetes with diabetic neuropathy, muscle weakness, and difficulty in walking. Review of a care plan dated 09/10/25 revealed Resident #22 required hyperglycemic medication related to diabetes. Goals included Resident #22 would exhibit a therapeutic effect related to the use of medication, would not have signs or symptoms of hyperglycemia, and would not have side effects related to the medication. Interventions included to administer medications per orders, vital signs as indicated, pharmacy review as indicated, finger sticks as ordered and report abnormal findings to physician, labs as orders and report abnormal results to physician, observe for signs and symptoms of hyperglycemia (flushed skin, dry skin, drowsiness, nausea, vomiting, abdominal pain, increased respiration) and report to physician, observe for signs and symptoms of hypoglycemia (dizziness, lethargy, diaphoresis, headache, irritability, confusion, restlessness, shallow respirations) and notify physician, observe for symptoms of lactic acidosis and immediately report to physician (feeling tired or weak, muscle pain, trouble breathing, abdominal pain, feeling cold, cold or blue hands and feet, dizziness or light headedness, slow or irregular heartbeat, persistent nausea and/or vomiting, shortness of breath and an enlarged or tender liver or weight loss). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had mildly impaired cognition, refused care one to three days, and required (staff) supervision or touching assistance for transfers and bed mobility. Review of an order dated 09/18/25 revealed Resident #22 had an order to receive insulin glargine subcutaneous solution pen-injector 100 units/milliliters (ml) 15 units subcutaneously one time a day at 9:00 A.M. for diabetes. Review of an order dated 10/21/25 revealed Resident #22 was to receive Novolog injection solution 100 unit/ml as per sliding scale (depending on fingerstick blood sugar results) four times a day with blood sugar checks scheduled to be obtained at 9:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M. If the resident's blood sugar was 150-200 (mg/dL) give 4 units, if 201-250 give 6 units, if 251-300 give 10 units, if 301-350 give 15 units, if 351-400 give 18 units, if 401-450 give 22 units subcutaneously four times a day for diabetes with instructions to call physician if blood sugar was greater than 450 or less than 75. Review of a progress note dated 10/21/25 by Certified Nurse Practitioner (CNP) #515 revealed Resident #22 had been having intermittent hypoglycemia despite an elevated glycated hemoglobin (A1c), but was not experiencing hyperglycemia with blood sugar ranging from 350-528. The progress note revealed hyperglycemia was improved with additional Novolog. Review of a nursing note dated 11/02/25 at 1:57 P.M. authored by Registered Nurse (RN) #156 revealed Resident #22's blood sugar showed hi on two devices. The on-call company (of medical providers) was called, and orders were received to give 26 units of Novolog and call back in two hours. The 26 units of Novolog insulin was documented as given. Review of a nursing note dated

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 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, interview, review of staff schedules, review of the facility assessment, and policy review, the facility failed to maintain safe staffing levels to prevent harm to residents. This affected one (#22) of three residents reviewed and had the potential to affect 19 additional residents residing on the 400 unit. The facility census was 53. Findings include:Review of Resident #22's closed medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including type I diabetes with diabetic neuropathy, muscle weakness, and difficulty in walking. Review of a care plan dated 09/10/25 revealed Resident #22 required hyperglycemic medication related to diabetes. Goals included Resident #22 would exhibit a therapeutic effect related to the use of medication, would not have signs or symptoms of hyperglycemia, and would not have side effects related to the medication. Interventions included to administer medications per orders, vital signs as indicated, pharmacy review as indicated, finger sticks as ordered and report abnormal findings to physician, labs as orders and report abnormal results to physician, observe for signs and symptoms of hyperglycemia (flushed skin, dry skin, drowsiness, nausea, vomiting, abdominal pain, increased respiration) and report to physician, observe for signs and symptoms of hypoglycemia (dizziness, lethargy, diaphoresis, headache, irritability, confusion, restlessness, shallow respirations) and notify physician, observe for symptoms of lactic acidosis and immediately report to physician (feeling tired or weak, muscle pain, trouble breathing, abdominal pain, feeling cold, cold or blue hands and feet, dizziness or light headedness, slow or irregular heartbeat, persistent nausea and/or vomiting, shortness of breath and an enlarged or tender liver or weight loss). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had mildly impaired cognition, refused care one to three days, and required (staff) supervision or touching assistance for transfers and bed mobility. Review of an order dated 09/18/25 revealed Resident #22 had an order to receive insulin glargine subcutaneous solution pen-injector 100 units/milliliters (ml) 15 units subcutaneously one time a day at 9:00 A.M. for diabetes. Review of an order dated 10/21/25 revealed Resident #22 was to receive Novolog injection solution 100 unit/ml as per sliding scale (depending on fingerstick blood sugar results) four times a day at 9 A.M., 12 P.M., 5 P.M., and 9 P.M. If the resident's blood sugar was 150-200 (mg/dL) give 4 units, if 201-250 give 6 units, if 251-300 give 10 units, if 301-350 give 15 units, if 351-400 give 18 units, if 401-450 give 22 units subcutaneously four times a day for diabetes with instructions to call physician if blood sugar was greater than 450 or less than 75. Review of a progress note dated 10/21/25 by Certified Nurse Practitioner (CNP) #515 revealed Resident #22 had been having intermittent hypoglycemia despite an elevated glycated hemoglobin (A1c), but was not experiencing hyperglycemia with blood sugar ranging from 350-528. Hyperglycemia was improved with additional Novolog. Review of a nursing note dated 11/02/25 at 1:57 P.M. authored by Registered Nurse (RN) #156 revealed Resident #22's blood sugar showed hi on two devices. The on-call company (of medical providers) was called, and orders were received to give 26 units of Novolog and call back in two hours. The 26 units of Novolog insulin was documented as given. Review of a nursing note dated 11/02/25 at 3:14 P.M. authored by RN #156 revealed Resident #22's blood sugar was 477 (hyperglycemic), the on-call physician was called again and per their request 26 units (of Novolog insulin) was given with instructions to call back in two hours. Review of a nursing note dated 11/02/25 at 4:10 P.M. authored by RN #156 revealed Resident #22 had a fall in the morning while attempting to stand up to get a cup for ice. Resident #22 stated she stood up, then slid to the floor but did not hit her head. Resident #22 had a skin tear on her right elbow which was cleaned with wound cleanser and covered with a bordered gauze. (Note- this is a late entry note for a fall that had occurred 11/02/25 earlier in the day in the dining room). Record review and review of a facility fall investigation revealed no evidence a root cause analysis was completed or evidence the facility considered the resident's fall to be associated with her elevated blood sugar levels that had been identified on this date. Review of a nursing note dated 11/02/25 at 4:52 P.M. authored by RN #156 revealed Resident #22's blood sugar showed hi on two devices. The on-call company (of medical providers) was called, and orders were received to give 26 units of Novolog insulin and call back in two hours. The 26 units of Novolog insulin were documented as given. Review of a nursing note dated 11/02/25 at 4:57 P.M. authored by RN #156 revealed Resident #22's blood sugar was 477 mg/dL, the on-call physician was called again and per their request 26 units were given with instructions to call back in two hours. Review of a nursing note dated 11/02/25 at 6:08 P.M. authored by RN #156 revealed Resident #22's blood sugar was 347 mg/dL. The note included

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 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 medical record review, facility incident report review, interview and facility policy review, the facility failed to ensure residents were free from unnecessary medication. This affected two residents (#54 and #87) of five residents reviewed for medication administration errors. The facility census was 53. Findings include:1. Review of the medical record for Resident #54 revealed an initial admission date of 10/18/25 with the diagnoses including but not limited to cerebral infarction, encounter for palliative care, aphasia, contusion of scalp, chronic obstructive pulmonary disease, protein calorie malnutrition, age related physical debility, hydronephrosis, dysphagia, pressure induced deep tissue damage to right heel, disorders of lungs and anxiety disorder. Review of the plan of care dated 10/20/25 revealed the resident required the use of anti-anxiety medication (Lorazepam) related to diagnosis of anxiety disorder. Interventions included administer antianxiety medications as ordered by the physician. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was taking antianxiety medications. Review of the resident's monthly physician orders for November 2025 identified orders dated 11/11/25 Lorazepam 0.25 milligrams (mg) by mouth twice daily for anxiety, give half of 0.5 mg tablet to equal the 0.25 mg ordered dose, and Lorazepam 0. 5 mg by mouth every four hours as needed for anxiety/restlessness. Review of the progress note dated 10/26/25 at 7:38 P.M. revealed a medication error was observed during medication pass of Lorazepam 0.25 milligrams (mg) twice daily as the resident was being administered the Lorazepam 0.5 mg instead of the Lorazepam 0.25 mg. Review of the facility's incident report dated 10/26/25 at 7:00 P.M. revealed during medication pass it was discovered by the nurse that the staff nurses were signing off the resident was receiving Lorazepam 0.5 mg twice daily, however the resident's order was for Lorazepam 0.25 mg twice daily. The resident's Lorazepam 0.5 mg was to be used as needed only. On 10/27/25 the nurse was provided with verbal education about the five rights of medication administration and notifying pharmacy for label clarification as needed. Review of the resident's controlled drug receipt/record disposition form for the resident's Lorazepam 0.5 mg by mouth from 11/08/25 through 11/20/25 revealed the resident was administered Lorazepam 0.5 mg instead of Lorazepam 0.25 mg on 11/11/25 at 8:25 P.M., 11/12/25 at 8:17 A. M. and 8:34 P.M., 11/13/25 at 8:11 A.M. and 8:31 P.M., 11/14/25 at 7:02 P.M., 11/15/25 at 8:07 A.M. and 9:18 P.M., 11/16/25 at 8:09 A.M. and 8:26 P.M., 11/17/25 at 8:05 A.M., 11/18/25 at 7:56 A.M. and 7:56 P.M., 11/19/25 at 8:55 A.M. and 8:16 P.M. and 11/20/25 at 9:02 A.M. Further review revealed no evidence that the Lorazepam 0.5 mg by mouth was administered for the as needed dosage. On 11/20/25 at 3:55 P.M., interview with the Regional Nurse #510 verified the resident received the wrong dose of Lorazepam on the listed dates and verified the resident should have received Lorazepam 0.25 mg by mouth. 2. Review of the medical record for Resident #87 revealed an initial admission date of 04/19/23 with the latest readmission of 04/04/24 with diagnoses including but not limited to chronic obstructive pulmonary disease, cirrhosis of liver, alcoholic cirrhosis of liver with ascites, esophageal varices, with bleeding, scoliosis, pain in right shoulder, rotator cuff tear or rupture, depression and systemic inflammatory response syndrome. Review of the plan of care dated 06/20/23 revealed the resident had pain/discomfort related to arthritis, right shoulder pain and left should rotator cuff tear. Interventions included administer pain medications per physician orders. Assess for pain, monitor and report non-verbal signs of pain and orthopedic appointments as ordered. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident utilized scheduled, as needed, and non-pharmacological interventions for pain relief. The assessment indicated the resident had frequent pain at a level of seven out of 10 with zero being no pain and 10 being the worst pain possible. Review of the resident's monthly physician orders for November 2025 identified orders dated 06/02/25 for Oxycodone 5 mg by mouth every six hours for pain; and Hydromorphone 2 mg by mouth every four hours as needed for pain at the level of six to10. Review of the facility incident report dated 11/02/25 at 7:30 P.M. revealed during the narcotic shift count it was discovered the resident was administered an extra dose of Oxycodone 5 mg by mouth. Review of the resident's controlled drug receipt/record disposition form for the resident's Oxycodone 5 mg by mouth revealed on 11/02/25 the resident was administered an extra dose of Oxycodone 5 mg by mouth at 10:39 A.M. with a physician's order.Review of the resident's medical record revealed no evidence a physician ordered for Resident #87 to receive an extra dose of Oxycodone 5 mg Review of the resident's November MAR revealed