STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review, interview, and policy review, the facility failed to ensure code status forms were in the medical record. This affected one (#116) of three residents reviewed for code status. The facility census was 113.Findings include:Review of the medical record for Former Resident (FR #116) revealed an admission date of 11/12/26 and discharge date of 01/09/25 with diagnoses including but not limited to sepsis due to enterococcus, acute and subacute infective endocarditis, bacteremia, urinary tract infection, and acute pulmonary edema.Review of the care plan dated 11/12/25 revealed FR #116 had an advanced directive of Do Not Resuscitate Comfort Care Arrest (DNRCCA). Interventions included but not limited to code status will be in the medical record at all times.Review of physician order revealed code status DNRCCA from 11/12/25 through 01/09/26.Review of scanned documents in the electronic record (PCC) revealed no advanced directive DNRCCA was scanned into PCC upon admission through discharge.Review of eInteract hospital transfer form dated 01/09/26 revealed code status DNRCCA with no signed code status paper on file.Interview on 04/22/26 at 8:15 A.M. with the Director of Nursing (DON) revealed the DNRCCA paperwork for FR #116 was in medical records. DON denied knowing why the form was not scanned into PCC. DON verified the DNRCCA was not scanned into PCC for the nurses to have access to it.Interview on 04/23/26 at 8:23 A.M. via phone with Licensed Practical Nurse (LPN #302) revealed that they could not locate the DNRCCA paperwork for FR #116 to send with the resident to the Emergency Department.Review of policy titled, Advanced Directives, dated 2001 revealed if the resident or the residents representative has executed one or more advance directive, or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.This deficiency represents noncompliance investigated under Complaint Number 2717941.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on medical record review, staff interview, and policy review, the facility failed to report an injury of unknown origin to the State Agency as required. This affected one (#84) resident out of three residents reviewed for incidents/accidents. The facility census was 113. Findings include:Review of the medical record for Resident #84 revealed an admission date of 11/22/24 with medical diagnoses of chronic obstructive pulmonary disease, anxiety, diabetes mellitus, hypertension, and unspecified hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/27/26, revealed Resident #84 had moderate cognitive impairment and was dependent upon staff for toilet hygiene, bed mobility, transfers, and bathing. Review of nurse's notes for Resident #84 revealed a note dated 08/04/25 at 11:49 A.M. which stated the nurse went into Resident #84's room due to resident being on the floor. The note stated Resident #84 was observed lying on her bedroom floor with her back to the floor and head against the bedside stand. The note indicated Resident #84's family, Certified Nurse Practitioner (CNP), and Director of Nursing (DON) were notified. The note stated orders received for x-rays.Review of nurse's note dated 08/05/25 at 11:53pm stated the x-rays of Resident #84's right arm and leg were negative for fractures.Review of Resident #84's nurses' note, dated 09/07/25 at 6:54pm, stated an x-ray reviewed at this time by CNP and an order for computed tomography (CT) scan without contrast was to be completed.Further review of Resident #84's nurses notes revealed a note dated 10/23/25 at 6:06 A.M. which stated CNP was notified of Resident #84's right hip fracture.Review of the x-ray results dated 08/05/25 for Resident #84's right humerus and right femur revealed no evidence of fracture of dislocation and diffuse osteopenia. Review of x-ray results of Resident #84's right hip, dated 08/23/25, revealed no evidence of a fracture. Review of x-ray results dated 09/06/25 of Resident #84's right hip with unilateral pelvis revealed a cortical breach with a small step deformity on the medial aspect of the femoral neck which is only seen on the oblique projection and diffuse osteopenia. No evidence of dislocation was noted. A CT was recommended for further evaluation of the hip joint. Review of Resident #84's CT scan of right hip, dated 10/16/25, revealed nondisplaced right intertrochanteric femur fracture. Interview on 04/22/26 at 8:19 A.M. with DON stated Resident #84 had multiple x-rays done to her right hip and leg after the fall on 08/04/25 because of continued complaints of pain and all were negative for fractures until 09/06/25. DON stated Resident #84 refused to have a CT scan done on 09/17/25 and it was rescheduled for 10/13/25. DON confirmed the CT scan on 10/13/25 showed a nondisplaced right intertrochanteric femur fracture. DON stated the facility did not believe the fracture occurred from the fall on 08/04/25 but could not say what caused the fracture found on the CT scan on 10/13/25. DON stated Resident #84 was dependent upon staff for all transfers, toileting, and bed mobility and could not say if the fracture was caused during routine care. DON stated the facility Medical Director documented in a progress note dated 10/13/25 that the fracture was pathological due to her disease processes. DON confirmed the facility had not completed a Facility-Reported Incident (FRI) report, completed an investigation into the injury of unknown origin, or reported the injury of unknown origin to the State Agency when identified on 10/13/25. Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021 stated residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. The policy stated to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property and to investigate and report any allegations within timeframes required by federal requirements.This was an incidental finding discovered over the course of the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review, staff interview, and policy review, the facility failed to investigate an injury of unknown origin. This affected one (#84) resident of the three residents reviewed for incidents/accidents. The facility census was 113. Findings include:Review of the medical record for Resident #84 revealed an admission date of 11/22/24 with medical diagnoses of chronic obstructive pulmonary disease, anxiety, diabetes mellitus, hypertension, and unspecified hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/27/26, revealed Resident #84 had moderate cognitive impairment and was dependent upon staff for toilet hygiene, bed mobility, transfers, and bathing. Review of nurse's notes for Resident #84 revealed a note dated 08/04/25 at 11:49 A.M. which stated the nurse went into Resident #84's room due to resident being on the floor. The note stated Resident #84 was observed lying on her bedroom floor with her back to the floor and head against the bedside stand. The note indicated Resident #84's family, Certified Nurse Practitioner (CNP), and Director of Nursing (DON) were notified. The note stated orders received for x-rays.Review of nurse's note dated 08/05/25 at 11:53pm stated the x-rays of Resident #84's right arm and leg were negative for fractures.Review of Resident #84's nurses' note, dated 09/07/25 at 6:54pm, stated an x-ray reviewed at this time by CNP and an order for computed tomography (CT) scan without contrast was to be completed.Further review of Resident #84's nurses notes revealed a note dated 10/23/25 at 6:06 A.M. which stated CNP was notified of Resident #84's right hip fracture.Review of the x-ray results dated 08/05/25 for Resident #84's right humerus and right femur revealed no evidence of fracture of dislocation and diffuse osteopenia. Review of x-ray results of Resident #84's right hip, dated 08/23/25, revealed no evidence of a fracture. Review of x-ray results dated 09/06/25 of Resident #84's right hip with unilateral pelvis revealed a cortical breach with a small step deformity on the medial aspect of the femoral neck which is only seen on the oblique projection and diffuse osteopenia. No evidence of dislocation was noted. A CT was recommended for further evaluation of the hip joint. Review of Resident #84's CT scan of right hip, dated 10/16/25, revealed nondisplaced right intertrochanteric femur fracture. Interview on 04/22/26 at 8:19 A.M. with DON stated Resident #84 had multiple x-rays done to her right hip and leg after the fall on 08/04/25 because of continued complaints of pain and all were negative for fractures until 09/06/25. DON stated Resident #84 refused to have a CT scan done on 09/17/25 and it was rescheduled for 10/13/25. DON confirmed the CT scan on 10/13/25 showed a nondisplaced right intertrochanteric femur fracture. DON stated the facility did not believe the fracture occurred from the fall on 08/04/25 but could not say what caused the fracture found on the CT scan on 10/13/25. DON stated Resident #84 was dependent upon staff for all transfers, toileting, and bed mobility and could not say if the fracture was caused during routine care. DON stated the facility Medical Director documented in a progress note dated 10/13/25 that the fracture was pathological due to her disease processes. DON confirmed the facility had not completed a Facility-Reported Incident (FRI) report, completed an investigation into the injury of unknown origin, or reported the injury of unknown origin to the State Agency when identified on 10/13/25. Review of the facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised April 2021 stated residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. The policy stated to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property and to investigate and report any allegations within timeframes required by federal requirements.This was an incidental finding discovered over the course of the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interview, and policy review, the facility failed to ensure the comprehensive care plan included all skin issues. This affected one (#68) of four residents reviewed for wounds. The facility census was 113.Findings include:Review of medical record for Resident #68 revealed an admission date of 03/14/26 with diagnoses including but not limited to pressure ulcer of left heel stage two (partial thickness skin loss involving the epidermis and dermis) and pressure ulcer of right heel stage three (full thickness skin injury characterized by a deep crater like wound that exposes fatty tissue).Review of current physician orders revealed wound care for pressure to right heel: cleanse with normal saline (NS), pat dry, apply betadine wet to dry sterile dressing, cover with ABD and wrap with kerlix (apply betadine only to wound area) daily and as needed. Apply antibiotic cream and Band-Aid to left heel daily, offload right foot at all times while in bed, and wear heelless shoe to right foot while ambulating.Review of care plan dated 03/14/26 revealed the resident was at risk for pressure ulcers and other skin problems such as skin tears, bruising, bleeding, abrasions, rashes, excoriation related to decreased mobility with diabetes. Wound to left heel. Interventions included monitor hydration every shift, monitor skin daily with routine care, pressure redistribution cushion to wheelchair, pressure redistribution mattress to bed, and weekly skin assessment per nurse.Interview on 04/22/26 at 2:00 P.M. with Director of Nursing (DON) verified there was no care plan for the pressure ulcer to the right heel or the interventions for the heelless shoe or offloading.Review of policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022 revealed the comprehensive, person-centered care plan includes measurable objectives and times, describes the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being, includes the resident's stated goals upon admission and desired outcomes, builds on the resident's strengths, and reflects currently recognized standards of practice for problem areas and conditions.This was an incidental finding discovered over the course of the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, and policy reviews, the facility failed to ensure comprehensive skin evaluations were completed upon admission for Resident #35 and failed to ensure wound care was completed as per physician orders for Resident #117. This affected two (#35 and #117) residents out of the three residents reviewed for skin breakdown. The facility census was 113.Findings include:1.Review of the medical record for Resident #35 revealed an admission date of 03/13/26 with diagnoses of end stage renal disease, chronic obstructive pulmonary disease, anemia, and peripheral vascular disease. Review of the medical record revealed Resident #35 discharged to the hospital on [DATE] and readmitted to the facility on [DATE].Review of Resident #35's admission Minimum Data Set (MDS) assessment, dated 03/15/26, indicated Resident #35 was cognitively intact and was dependent upon staff for toilet hygiene and transfers, required partial/moderate staff assistance with eating, and supervision with bed mobility. The MDS indicated Resident #35 admitted with surgical wounds. Review of the medical record for Resident #35 revealed a Nursing admission evaluation, dated 03/13/26, which stated Resident #35 was admitted for wound care/wound vac (Vacuum-Assisted closure- a medical device that uses continuous or intermittent suction to accelerate healing in acute or chronic wounds by removing excess fluid, decreasing bacteria, and increasing blood flow) and had multiple skin issues. Review of the evaluation revealed no documentation to support the location, description or measurements of the wounds. Review of a skin issue evaluation, dated 03/17/26, indicated Resident #35 had a surgical wound to front right trochanter (large bony prominence on the upper, outer side of the femur that serves as a crucial attachment point for hip muscles) which measured 10.34 centimeter (cm) by 6.44 cm by 3.2 cm.Review of the Nursing admission evaluation, dated 03/25/26, indicated Resident #35 had no skin issues.Review of the skin issue evaluation, dated 03/31/26, indicated Resident #35 admitted with a surgical site to front right trochanter which measured 7.5 cm by 5.75 cm by 3 cm and was present upon admission.Interview on 04/23/26 at 11:15 A.M. with Director of Nursing (DON) confirmed the medical record for Resident #35 did not have documentation to support the facility completed comprehensive skin evaluations upon admission on [DATE] and 03/25/26 to include the location, description, or measurements of the surgical wound. DON stated the expectation was for staff to complete comprehensive wound assessments upon admission that would include the location, description, and measurements of the wounds.2. Review of the medical record for Resident #117 revealed an admission date of 01/27/26 with medical diagnoses of atherosclerosis of native arteries of left leg with gangrene, left above the knee amputation (AKA), peripheral vascular disease, diabetes mellitus, and congestive heart failure. Review of the medical record revealed Resident #117 discharged to the hospital on [DATE], readmitted to the facility on [DATE], discharged to the hospital on [DATE], readmitted to the facility on [DATE], and discharged to the hospital on [DATE] and had not returned. Review of Resident #117's admission MDS assessment, dated 02/03/26, revealed Resident #117 was cognitively intact and required substantial/maximum staff assistance for toilet hygiene, bathing, and bed mobility and was dependent upon staff for transfers. The MDS indicated Resident #117 had a surgical site. Review of Resident #117's medical record revealed a wound assessment dated [DATE] which indicated Resident #117 had a surgical site to right foot fifth toe which measured 0.37 cm by 0.32 cm by 0.1 cm, a deep tissue injury pressure ulcer to right heel which measured 3.26 cm by 2.64 cm by 0.2cm, and surgical site to left lateral thigh which measured 4.07 cm by 11.93cm by 0.9cm. The assessment indicated all wounds were present upon readmission on [DATE].Review of the physician orders for Resident #117 revealed orders dated 02/26/26 to surgical amputation site to right foot fifth toe to cleanse with normal saline, pat dry, apply betadine, cover with abdominal pad (ABD) and wrap with kerlix every night shift and for right heel wound to cleanse with normal saline, pat dry, apply betadine, cover with ABD, and wrap with kerlix every night (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift. Further review of Resident #117's physician orders revealed an order dated 02/26/26 to change dressing to wound vac every Tuesday, Thursday, and Saturday and an order dated 03/03/26 for wound vac therapy to left AKA bridged to left lateral thigh to ensure wound vac dressing was sealed/intact and setting at 125 millimeters of mercury (mmHG) continuous therapy. Review of the Resident #117's March 2026 Treatment Administration Record (TAR) revealed no documentation to support wound care was completed to right foot fifth toe surgical site or right heel wound on 03/09/26, 03/10/26, and 03/13/26. Further review revealed no documentation to support wound vac dressing was changed on 03/05/26 or documentation to support the wound vac was properly functioning on 03/05/26, 03/11/26, and 03/13/26.Interview on 04/22/26 at 1:57 P.M. with Director of Nursing (DON) confirmed the medical record for Resident #117 did not have documentation to support wound care was completed as ordered to the left lateral thigh or right foot fifth toe surgical sites or pressure ulcer to right heel on 03/05/26, 03/09/26, 03/10/26, 03/11/26, and 03/13/26. Review of the facility policy titled, Pressure Injury Risk Assessment, revised March 2020 stated purpose was to provide guidelines for the structured assessments and identification of residents at risk of developing new pressure injures or worsening of exiting pressure injuries. The policy stated the following should be recorded in the resident's medical record utilizing facility forms: 1) type of assessment conducted, 2) dates, time, and type of skin care provided, if appropriate, 3) the name and initials of the individual who conducted the assessment, 4) any change in the resident's condition, 5) the condition of the resident's skin (i.e., size and location of any red or tender areas) if identified, 6) how the resident tolerated the procedure or his/her ability to participate in the procedure, 7) any problems or complaints made by the resident related to the procedure, 8) if the resident refused the treatment and reason why, document family and physician notification of refusal, 9) observations of anything unusual exhibited by the resident, 10) initiation of (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted, 12) documentation in the medical record addressing MD notification if new skin alteration noted with change of plan of care, if indicated, 13) documentation in medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care, if indicated.Review of the facility policy titled, Prevention of Pressure Injuries, revised April 2020 stated staff are to conduct a comprehensive skin assessment upon admission (or soon after) admission, with each risk assessment, as indicated according to resident's risk factors, and prior to discharge.This deficiency represents non-compliance investigated under Complaint Number 2979521.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, staff and resident interviews, and policy review, the facility failed to provide care/services to prevent a fall. This affected one (#84) resident out of three residents reviewed for falls. The facility census was 113.Findings include:Review of the medical record for Resident #84 revealed an admission date of 11/22/24 with medical diagnoses of chronic obstructive pulmonary disease, anxiety, diabetes mellitus, hypertension, and unspecified hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/27/26, revealed Resident #84 had moderate cognitive impairment and was dependent upon staff for toilet hygiene, bed mobility, transfers, and bathing. Review of the physician orders for Resident #84 revealed an order dated 01/14/25 for pressure reduction mattress to bed.Review of nurse's notes for Resident #84 revealed a note dated 08/04/25 at 11:49 A.M. which stated the nurse went into Resident #84's room due to resident being on the floor. The note stated Resident #84 was observed lying on her bedroom floor with her back to the floor and head against the bedside stand. The note stated Resident #84 stated the Certified Nursing Assistant (CNA) left her alone in the room to obtain more linen and she fell out of bed onto the floor. Resident #84 expressed pain in her right leg and right arm. The note indicated Resident #84's family, the Certified Nurse Practitioner (CNP), and the Director of Nursing (DON) were notified. The note stated orders received for x-rays. Review of nurse's note dated 08/05/25 at 11:53pm stated the x-rays of Resident #84's right arm and leg were negative for fractures. Interview on 04/20/26 at 10:27 A.M. with Resident #84 stated she fell out of bed several months ago after an aide left her on her side while performing incontinence care to go get more linen from the linen closet. Resident #84 stated she was on low air loss mattress and the mattress inflated and pushed her out of the bed. Interview on 04/21/26 at 10:32 A.M. with CNA #130 confirmed she was providing incontinence care for Resident #84 when she left Resident #84 on her side in her bed to go get more linen. CNA #130 stated when she returned to the room Resident #84 had fallen out of bed and was lying on the floor. CNA #130 stated she did not lower Resident #84's bed to the lowest position when she left the room to get linens but instead stated the bed was at waist level height. CNA #130 confirmed she was the only staff member providing care for Resident #84 at that time and that Resident #84 required two-person assist for incontinence cares and bed mobility. Interview on 04/22/26 at 8:19 A.M. with DON confirmed Resident #84 required two-person assistance for bed mobility, transfers, and incontinence cares. DON confirmed that on 08/04/25 CNA #130 left Resident #84 alone on her side on a low air loss mattress and left the room to get more linen which resulted in Resident #84 falling out of bed. Review of the facility policy titled, Falls-Clinical Protocol, revised March 2018 stated would evaluate and document falls that occur while the individual was in the facility and should be identified as witnessed or unwitnessed events. The staff, with the physician's guidance, would follow up on any fall associated injury until the resident was stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved.This deficiency represents non-compliance investigated under Complaint Number 2714112.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366304	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Valley Post Acute	400 Barks Road West Marion, OH 43302

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, dishwasher temp logs, manufacturer recommendations, interview, and policy review the facility failed to ensure the dishwasher temp was high enough for sanitation. This had the potential to affect all residents who reside in the facility. The facility census was 113.Findings include:Observation on 04/20/26 at 9:31 A.M. of the dishwasher revealed the tag on front of dishwasher minimum temperature of wash cycle was 159 degrees Fahrenheit (F), pump rinse of 160 degrees F, and final rinse of 180 degrees F with 20 psi pressure. Observation of the dishwasher not running revealed a wash temp of 160 degrees, rinse pump 170 degrees F, and final rinse of 178 degrees F. Observation of the dishwasher running revealed the was temp gauge moved to 162 degrees F, the rinse pump gauge did not move at all, and the final rinse gauge did not move at all. The dishwasher did not kick on for the pump rinse or the final rinse and pushed the tray out the end of the conveyor belt. Observation times two trays coming through the dishwasher where the rinses did not kick on for each observation.Interview on 04/20/26 at 9:41 A.M. with Dietary Manager (DM #272) revealed the dishwasher was spraying water continuously in the machine but verified the machine did not kick on for the rinse cycles. DM #272 stated that when the dishes were pushed into the machine the wash cycle gauge moved and the rinse cycles did not kick on for the third observation. DM #272 instructed the staff to shut the machine off and reset to make sure the rinse cycle would turn on. Observation of the rinse cycle after the machine was reset revealed the rinse cycles still did not kick on after the wash cycle. DM #272 verified the dishwasher was a high temp machine. DM #272 stated the facility would serve on Styrofoam plates and handwash until the Maintenance Director (MD #342) looked at the dishwasher.Follow up observation and interviews on 04/21/26 at 9:05 A.M. of the dishwasher revealed that while the dishwasher was not running the temperatures on the wash gauge was 164 degrees F, pump rinse 162 degrees F, and final rinse 120 degrees F. Observation of the dishwasher running was wash gauge 150 degrees F, pump rinse 160 degrees F, and final rinse 170 degrees F times five cycles of the dishwasher. DM #272 and MD #342 were observing the dishwasher at the same time. DM #272 turned off the breaker and turned back on and ran the dishwasher for five more cycles with the same results. MD #342 and DM #272 verified the dishwasher was not washing or rinsing the dishes per the manufacturer recommendations. DM #272 stated that the dishes would be washed by hand and they would use Styrofoam until the technician came in the afternoon.Interview on 04/21/26 at 9:34 A.M. with MD #342 revealed that he reset the boiler yesterday and ran the dishwasher last evening and it was working correctly at that time. MD #342 verified the dishwasher temp logs for the past four months had multiple days that the temperatures of the final rinse were not at the recommended minimums.Review of high temperature dish machine log for April 2026 revealed the following rinse temperatures 04/07 supper 178 F, 04/08 177 F, 04/09 177 F, 04/12 supper 179 F, and 04/16 supper wash temp 150 F.Review of American dish service manufacturer manual revealed hot water sanitizing final sanitizing rinse minimum temperature: 180 F, pumped rinse tank minimum temperature of 160 F, wash tank minimum temperature of 150 F final rinse minimum pressure 20 psi, and maximum conveyor speed 6.8 feet per minute.Review of the facilities infection control log for the past four months revealed no food borne illnesses.Review of policy titled, Kitchen Infection Control Policy, not dated revealed dishwashing must meet temperature and sanitation standards.Review of policy titled, Sanitation, revised November 2022 revealed dishwashing machines are operated according to manufacture's instructions. General recommendations for heat and chemical sanitization are: high temperature dishwasher: wash temperature (150-165 F) and rinse temperature (180 F)- (160 F at the rack level/dish surface reflects 180 F at the manifold, which is the area just before the final rinse nozzle where the temperature of the dish machine is measured); or 165 F for a stationary rack, single temperature machine.This deficiency represents non compliance investigated under Complaint Number 2970467.