

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Waterview Pointe Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 117 Bartlett 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)		
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, beneficiary notice review, policy review and interview, the facility failed to ensure residents were informed of what type of skilled services were being terminated. This affected three residents (#2, #20 and #83) of three residents reviewed for beneficiary notifications. Findings include: Findings Include: 1. Medical record review revealed Resident #83 was admitted on [DATE] and discharged [DATE]. Review of the Notice of Medicare Non-Coverage dated 04/28/25 for Resident #83 revealed her skilled services were ending on 04/30/25. The facility failed to document what skilled services were ending on 04/30/25. 2. Medical record review revealed Resident #20 was admitted on [DATE]. Review of the Notice of Medicare Non-Coverage dated 04/08/25 for Resident #20 revealed current services were ending on 04/10/25. The facility failed to document what skilled services were ending on 04/10/25 for Resident #20. 3. Medical record review revealed Resident #2 was admitted on [DATE]. Review of the Notice of Medicare Non-Coverage dated 04/04/25 for Resident #2 revealed current therapy services was ending on 04/07/25. The facility failed to document what therapy services were ending on 04/07/25 for Resident #2. On 07/29/25 at 3:15 P.M., interview with the Director of Nursing stated the facility does not have a policy regarding beneficiary notifications and the facility was to follow federal guidelines. On 07/30/25 at 12:48 P.M., interview with Administrator verified the beneficiary notices did not indicate what skilled services were being terminated.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366478
		If continuation sheet Page 1 of 11

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of email correspondence to the local Ombudsman, and staff interview, the facility failed to ensure the State Ombudsman was notified of a resident's discharge from the facility. This affected one resident (#81) of three residents reviewed for discharge. Findings include: Review of Resident #81's closed medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, delusional disorder, anxiety disorder, and tremors. She had a discharge date to home on [DATE]. Review of Resident #81's Discharge Plan of Care and Recapitulation dated 06/13/25 revealed the resident was there for a respite stay. Review of an email correspondence from the facility's social worker (Social Service Designee #202) to the State Ombudsman's email address dated 07/07/25 at 4:04 P.M. revealed Social Service Designee (SSD) #202 sent an email notifying the local State Ombudsman of discharges that had occurred for the prior month (June 2025). There were 13 residents on that list but it did not include Resident #81, who had been discharged on 06/13/25. On 07/31/25 at 9:00 A.M., an interview with SSD #202 confirmed the email she sent to the State Ombudsman on 07/07/25 to notify them of the facility's discharges that occurred in June 2025 did not include the name of Resident #81. She further confirmed Resident #81 was discharged on 06/13/25 following her five day respite stay and should have been on that list. She reported she pulled up a report of all discharges for the previous month and used that report to add the names of the residents who had been discharged to an email she sent to the State Ombudsman to notify them of the facility's prior month's discharges. She stated all discharges including respite stays would be included on that list.		

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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 record review, observations, and interviews, the facility failed to attempt new interventions for skin conditions (non-pressure related) and behaviors for Resident #42. This affected one resident (#42) of two residents reviewed for skin conditions. Additionally, the facility failed to ensure residents were positioned appropriately in their wheelchair. This affected one resident (#45) of one resident reviewed for positioning. The facility census was 69. Findings include: 1. Record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies, seborrheic dermatitis, and psoriasis. Review of a care plan dated 06/27/22 revealed Resident #42 was at risk for alteration in skin integrity related to Lewy body dementia, pain, recent hip replacement, psoriasis- areas come and go (mainly on face)- picks at skin on face, and seborrheic dermatitis which comes and goes. Interventions included but were not limited to complete skin assessments per facility policy, notify the physician of changes as needed, provide skin care as needed, treatment per order, and provide resident/family with education on skin integrity maintenance and potential complications as needed. Review of a care plan dated 06/21/24 revealed Resident #42 had alteration in skin integrity as evidenced by rash present on her face, seborrheic dermatitis, and comes and goes. Interventions included but were not limited to body check weekly and as needed, notify physician and family of changes as needed, treatment per orders, and provide resident/family with education on skin impairment and potential complications as needed. Review of a note from Physician Assistant (PA) #313 dated 07/18/24 revealed Resident #42's seborrheic keratosis had improved with Ketoconazole. Review of a note from PA #313 dated 11/21/24 revealed Resident #42's face had improved related to seborrheic keratosis and to continue Econazole to face. Review of a psychiatric note dated 04/17/25 revealed Resident #42 had a medical history of psoriasis. The note did not address Resident #42's behavior of picking at her skin. Review of a psychiatric note dated 05/15/25 revealed Resident #42 had a medical history of psoriasis. The note did not address Resident #42's behavior of picking at her skin. Review of a note from Physician #325 dated 05/23/25 revealed Resident #42's diagnoses included psoriasis, however the skin portion of the documentation was left blank. Review of a minimum data set (MDS) completed on 06/30/25 revealed Resident #42 had mildly impaired cognition, no behaviors, and no skin issues. Review of a psychiatric note dated 07/17/25 revealed Resident #42 had a medical history of psoriasis. The note did not address Resident #42's behavior of picking at her skin. Review of a note from Physician #325 dated 07/21/25 revealed Resident #42's diagnoses including psoriasis, however the skin portion of the documentation was left blank. Observation on 07/28/25 at 3:07 P.M. revealed Resident #42 was resting in her bed with a quarter-size area on her forehead which appeared red and flaky and she was picking at her skin. Observation on 07/29/25 at 10:19 A.M. revealed Resident #42 was ambulating in her room with a front-wheeled walker. Resident #42 stated she was doing well. She did have patchy, dry skin on her forehead and the bridge of her nose was bright red. Interview on 07/29/25 at 1:22 P.M. with Certified Nursing Assistant (CNA) #192 revealed Resident #42 picks at her skin and has for as long as they've known each other. CNA #192 stated Resident #42 has a cream she receives daily or that she asks for daily. Interview on 07/29/25 at 1:37 P.M. with CNA #166 revealed Resident #42 digs at her skin even when she receives her skin cream. CNA #166 stated Resident #42 has dug at her skin for a long time, she will let it heal, then digs again and it usually happens on her face. Interview on 07/30/25 at 8:15 A.M. with the Director of Nursing (DON) confirmed psychiatric notes did not address the behaviors of Resident #42 picking at her skin, Physician #325's notes did not always have a complete assessment including skin but it could be because Resident #42's rashes fluctuate, and PA #313's notes since 11/2024 have not addressed new skin outbreaks or new interventions. The DON also confirmed there were no current notes indicating Resident #42 had areas of her skin on her face open. Interview on 07/30/25 at 8:19 A.M. with Resident #42 revealed having rashes on her skin is normal for her. During (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the interview, Resident #42 had a breakout across her forehead, a bright red area to the bridge of her nose, and a new, small area the size of a dime to her chin. Resident #42 requested cream for her skin at this time. Interview on 07/30/25 at 8:20 A.M. with Licensed Practical Nurse (LPN) #137 revealed Resident #42 had a cream for her face which she received with her medications and the cream was used daily. LPN #137 retrieved the cream from the treatment cart and it was econazole nitrate and ordered for Mondays and Fridays. 2. Record review revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, restlessness and agitation, and history of falling. Review of an MDS dated [DATE] revealed Resident #45 had severely impaired cognition, physical behaviors one to three days, and behaviors were worsening, and the resident was dependent on staff for activities of daily living. Review of a care plan dated 07/30/21 revealed Resident #45 was at risk for falls and has fall history, uses psychotropic medications, has impaired mobility, is incontinent, and has impaired cognition and communication. Interventions included but were not limited to not using footrests when in recliner. Observation on 07/28/25 at 9:34 A.M. revealed Resident #45 was in a reclining wheelchair in the dining room. She was noted to be fidgeting, and her feet were dangling due to no footrests in place. Interview on 07/29/25 at 1:37 P.M. with CNA #166 revealed Resident #45 stays in an upright position in her wheelchair when she's awake, but when she goes to sleep, they tilt the chair back. Resident #45 does not use the footrests because she will hit the back of her legs off the pegs. Interview on 07/30/25 at 8:15 A.M. with Certified Occupational Therapy Assistant (COTA) #222 revealed she was unable to recall information regarding Resident #45's chair or type of footrests used. Interview on 07/30/25 at 8:22 A.M. with CNA #166 revealed she was unable to locate Resident #45's footrests. Interview on 07/30/25 at 8:26 A.M. with CNA #166 revealed she retrieved COTA #222 to assist with footrests. COTA #222 brought a pair of standard footrests to try with Resident #45's wheelchair; they did not fit. COTA #222 went to search the common area for footrests and found them in the dining room. Footrest had peddles for feet and a pad to support the calves. There was no cushioning to prevent injuries if resident was restless. COTA #222 stated they had not tried a padded box footrest and they could try them instead of leaving Resident #45's feet dangling but they could not strap her in and if she wanted to slide down and get of the chair she could. CNA #166 stated she did not know where the footrests were because they hadn't been used in so long. Interview on 07/30/25 at 8:40 A.M. with CNA #166 revealed she found a cushioned box footrest and thought it would work well for Resident #45 so her feet aren't dangling and when she becomes restless, the padding will protect her legs.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe environment for a resident left unattended with medications. This affected one resident (#28) of 69 residents residing in the facility. The facility census was 69. Findings Include: Medical record review revealed Resident #28 was admitted on [DATE] with diagnoses including rheumatoid arthritis, anxiety disorder, chronic pain and cerebral infarction without residual deficits. Review of the electronic Order Summary Report dated 07/31/25 revealed no evidence the resident was capable to self-administer medications. There was also no physician order for Resident #28's medications could be left at bedside unsupervised by the nurse. On 07/31/25 at 7:45 A.M., the surveyor observed Licensed Practical Nurse (LPN) #130 at the medication cart in the 400 hallway preparing medications. Resident #28's door was closed and permission to enter the room was obtained after knocking on the door twice. As the surveyor entered the resident's room the resident was observed sitting in a wheelchair in front of her overbed table. A medication cup was observed on the resident's overbed table containing twelve (12) medications. A clear, plastic water cup containing a plastic spoon and a thick white, liquid medication was also observed sitting on the overbed table. The resident stated LPN #130 brought her morning medications and she was waiting for her breakfast to take them. Resident #28 verified the nurse left the medications for her to take later and he was not in her room. At 7:47 A.M., the surveyor opened the door and looked down the hallway. LPN #130 was not observed on the 400 hall. At 7:49 A.M., Resident #28's door opened and LPN #130 entered the room. The surveyor asked him about the pill and liquid medications left unsupervised on the resident's overbed table. LPN #130 verified he left the resident and her medications unsupervised but 'was coming back'. Review of the policy: Medication Administration (dated 06/21/17) revealed medications were to be administered by legally authorized and trained persons in accordance to applicable state, local and federal laws and consistent with accepted standards of practice. Medications were to be administered and staff was to remain with the resident while medication was swallowed. Medication was never to be left in a residents room without an order to do so.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to ensure the physician addressed all the recommendations made by the facility's consulting pharmacist for irregularities that were identified during their monthly medication regimen review. This affected two residents (#3 and #8) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included schizo-affective disorder, generalized anxiety disorder, and major depressive disorder. Review of a pharmacy recommendation following a monthly medication regimen review of Resident #3's medications on 03/19/25 revealed the facility's consulting pharmacist recommended the physician consider a gradual dosage reduction (GDR) attempt regarding the resident's use of Zyprexa 10 milligrams (mg) daily, Remeron 15 mg at bedtime, Buspar 10 mg daily, and Paxil 20 mg daily. The physician agreed with the recommendation for a GDR pertaining to the use of Zyprexa 10 mg daily decreasing the dose from 10 mg to 5 mg every day. He did not address the pharmacist's recommendations pertaining to the other three medications (Remeron, Buspar, or Paxil) and did not provide any resident specific rationale as to why a GDR attempt for those medications were contraindicated at that time. Review of a physician note for Resident #3 dated 03/21/25 revealed the resident was seen by his physician on that date and his Zyprexa was reduced. The physician's note did not address why a GDR for Remeron, Buspar, and Paxil were not appropriate for the resident at that time. On 07/29/25 at 2:05 P.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #3's physician did not fully address the pharmacist's recommendations on 03/19/25 pertaining to GDR's for all the resident's psychotropic medications. There was no documentation from the physician that addressed the recommendation for a GDR pertaining to the resident's Remeron, Buspar, and Paxil. The DON further confirmed there was no resident- specific rationale provided to support why a GDR for those other three psychotropic medications were contraindicated for the resident at that time. She stated the physician just addressed what he wanted to even though those recommendation grouped together the recommendations for other medications. She acknowledged all of the pharmacist's recommendations should be addressed for irregularities identified on the pharmacy recommendation forms. She stated the pharmacist had since started communicating the recommendations for each medication separately and was not grouping them all together on the same pharmacy recommendation sheet as was done on 03/19/25. 2. Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, major depression, anxiety disorder, bipolar disorder, hallucinations, and unspecified psychosis. Review of a care plan dated 03/16/23 revealed Resident #8 was at risk for side effects from psychotropic medications, antipsychotics due to diagnosis of dementia. The goal was for resident to have no drug related side effects and interventions included, but were not limited to, administer medications as ordered, complete abnormal involuntary movement assessment and report changes to physician, monitor for complications such as delirium and tardive dyskinesia, review medications for possible dose reduction, and taper medications as ordered. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed Resident #8 had an order in place for Seroquel (antipsychotic) 12.6 milligrams by mouth once daily related to psychosis and bipolar disorder (04/16/24), Seroquel 50 milligrams at bedtime for psychosis and bipolar disorder (04/16/24), and duloxetine (antidepressant) capsule delayed release particles 60 milligrams give one capsule by mouth daily (06/21/25). Review of a pharmacy recommendation dated 06/19/25 revealed a recommendation for gradual dose reduction for duloxetine 90 milligrams and Seroquel 12.5 milligrams in the morning and 50 milligrams at bedtime. Physician #400 agreed to reduce duloxetine to 60 milligrams daily but did not address the recommendation for Seroquel. Interview on 07/29/25 at 2:53 P.M. with the Director of Nursing (DON) confirmed multiple medications were listed for dose reduction on the pharmacy recommendation but the physician failed to address recommendation for all medications. Review of a policy titled Medication Monitoring dated 10/01/18 revealed a written report of all irregularities and recommendations resulting from the medication regimen review are provided to a facility designee for the attending physician, DON and Medical Director. The facility and attending physician must address the recommendations in a timely manner that meets the needs of the resident and should document what irregularity has been reviewed, what action has been taken to address the issues, and a rationale for accepting/declining the recommendation.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to follow physician ordered parameters for medication administration. This affected two residents (#3, #5) of five residents reviewed for medication regimens. Findings Include: 1. Review of Resident #3's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included Parkinson's disease, adult onset diabetes mellitus, malignant neoplasm of the colon, schizo-affective disorder of the bipolar type, and mild intellectual disabilities. Review of Resident #3's physician's orders revealed the resident had an order to receive Hydrocodone- Acetaminophen (Norco) 5-325 milligrams (mg) by mouth (po) every six hours prn for pain rating 5-10. That order originated on 07/18/25. He also had an order to receive Tylenol Extra Strength 500 mg tablets with directions to give two tablets every six hours prn for a pain rating of 1-5. Review of Resident #3's electronic medication administration record (eMAR) for June 2025 revealed the resident had an order to receive Norco 5-325 mg one tablet every four hours prn for pain levels between 5-7 and two tablets po every four hours prn for pain levels of 8-10. That order originated on 06/05/25. The resident was given two of the prn Norco 5-325 mg tablets four separate times when his pain level did not fall between the ordered parameters for administration of two tablets between a pain level of 8-10. He received those four doses of two Norco 5-325 mg tablets by mouth on 06/08/25 at 7:40 P.M., 06/09/25 at 8:54 A.M., 06/10/25 at 6:20 A.M., and 06/14/25 at 9:03 A.M. for pain levels of a 7 on 1-10 scale. He was not given just one tablet of the Norco 5-325 mg tablets for a pain level of 7 as ordered by the physician. Review of Resident #3's eMAR for July 2025 revealed the resident had orders in place to receive Norco 5-325 mg one tab po every six hours prn for a pain level between 5-10. He also had an order to receive Tylenol Extra Strength 500 mg tablets with directions to give two tablets po every six hours prn for pain levels between 1-5 on a 1-10 scale. The orders for both the Tylenol Extra Strength and the Norco originated on 07/18/25. The resident was given the Norco for pain levels outside the parameters ordered for administration by the physician. He received Norco 5-325 mg one tablet on 07/26/25 at 8:03 P.M. for a pain level of 2 and again on 07/28/25 at 12:07 P.M. for a pain level of 4 on a 1-10 scale. He was not given the Tylenol Extra Strength 500 mg tablets (two tablets= 1,000 mg) on a prn basis when his pain levels were only between 1-5 as ordered by the physician. On 07/29/25 at 2:05 P.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #3 did not receive his prn pain medication in accordance with the parameters set by the physician in the orders given for Norco and Tylenol Extra Strength. She acknowledged the resident received Norco multiple times for pain levels less than what was specified by the physician for administration. She further confirmed the nurses should be following the parameters given by the physician on when to administer the Tylenol Extra Strength or when to give the resident the narcotic pain medication (Norco) for more severe pain. Review of the facility's policy on Pain Assessment and Management dated 03/31/16 revealed the facility was to provide pharmacological interventions in accordance with physician's orders. 2. Medical record review revealed Resident #5 was admitted on [DATE] with diagnoses including Parkinson's disease with dyskinesia, end stage renal disease, hypertension, diabetes mellitus with (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetic peripheral angiopathy without gangrene, dependence on renal dialysis, unspecified dementia, polyneuropathy, and anxiety disorder. a. Review of the electronic Physician Orders revealed Resident #5 was ordered to receive metoprolol succinate extended release (hypertension) 25 milligrams (mg) every Tuesday, Wednesday, Thursday, Saturday and Sunday. The medication included physician parameters including to hold the medication if the resident's diastolic blood pressure (DBP) was less than 60 mmHg. Review of the electronic Medication Administration Record (eMAR) dated October 2024 revealed metoprolol succinate XR 25 (mg) was administered on 10/31/24 with a DBP of 116/45. Review of the eMAR dated November 2024 revealed metoprolol succinate XR was administered on 11/14/24 with a BP of 146/56. Review of the eMAR dated December 2024 revealed metoprolol succinate XR was administered on 12/15/24 with a BP of 128/54. Review of the eMAR dated January 2025 revealed metoprolol succinate XR was administered on 01/12/25 with a BP of 140/58, on 01/14/25 with a BP of 123/58 and on 01/28/25 with a BP of 121/56. b. Review of the electronic Physician Orders dated June 2025 and July 2025 revealed to administer Hydrocodone-Acetaminophen (opioid) 7.5-325 (mg) one tablet by mouth every six hours as needed for a pain rating of six to 10. Review of the eMAR dated June 2025 revealed Resident #5 was administered Hydrocodone-Acetaminophen on 06/03/25 for complaints of pain rated a four out of 10. Review of the eMAR dated July 2025 revealed Resident #5 was administered Hydrocodone-Acetaminophen on 07/01/25 for complaints of pain rated a four out of 10. On 07/31/25 at 10:08 A.M., interview with the Director of Nursing (DON) verified the above physician order parameters for metoprolol succinate and Hydrocodone-Acetaminophen were not followed for Resident #5 as ordered. c. Review of the Infection Report Form dated 06/28/25 revealed Resident #5 had green-brown eye discharge from the right eye. Criteria was met for a nosocomial eye infection, the resident was diagnosed with blepharitis and ordered antibiotics. Review of the electronic Physician Orders and the eMAR dated June 2025 and July 2025 revealed Ciprofloxacin 0.3% (antibiotic) was ordered to administer two drops to the right eye while awake due to blepharitis. The order was entered into the system to start administration on 06/29/25; however, the order was discontinued on 06/28/25 at 5:31 P.M The Ciprofloxacin was not re-ordered until 06/29/25 at 8:00 A.M. and then was discontinued at 1:15 P.M. on 06/29/25. There was no evidence the Ciprofloxacin 0.3% order was entered back into the electronic ordering system until 07/01/25 at 12:00 A.M The first dose of Ciprofloxacin eye drops being administered to Resident #5 was on 07/02/25 at 4:00 A.M Review of the pharmacy DeliveryTrack Manifest dated 07/02/25 revealed Resident #5's Ciprofloxacin (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Waterview Pointe Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 117 Bartlett 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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ophthalmic solution 0.3% was delivered to the facility on [DATE] at 3:07 A.M On 07/29/25 at 5:00 P.M., interview with the DON verified Resident #5 did not receive the above antibiotic timely stating it was due to the pharmacy did not have it available to send to the facility. On 07/30/25 at 8:27 A.M., phone interview with certified pharmacy technician (CPT) #205 stated the pharmacy received orders directly from the facility electronic documentation system. CPT #205 stated Resident #5's ciprofloxacin 0.3% eye drops were not entered into the electronic ordering system until 06/29/25 after regular hours; therefore, the pharmacy did not receive the order until 06/30/25, the ciprofloxacin order was filled on 07/01/25 and delivered to the facility on [DATE] at 3:07 A.M. CPT #205 stated the facility has an option to have the pharmacy drop ship or STAT deliver medications if needed sooner but this was not requested. CPT #205 stated the medication was available for delivery and this did not impact this ordered medication. On 07/30/25 at 3:35 P.M., interview with Licensed Practical Nurse (LPN) #118 stated the cut off time to have medications delivered in the next tote was 6:00 P.M LPN #118 stated any orders entered after 6:00 P.M. would not be delivered until the next daily tote delivery which arrives at approximately 3:00 A.M. daily to the facility. Any medications including antibiotics that were needed sooner would need to be called for a STAT order. Review of the policy: 3.4.2. Delivery and Receipt of Non-Cycle Fill Paxit Medication (dated 06/21/17) revealed the purpose was to establish the proper procedure for the receipt of Non-Cycle Fill 24 hour unit dose Paxit medications from the pharmacy by authorized facility staff. Nursing staff at the facility were responsible for verifying the accuracy of the delivery and notifying the pharmacy of any discrepancies within four hours of delivery. Procedure included: The pharmacy delivers the Non-Cycle Fill medications to the facility with each delivery, according to a facility specific predetermined schedule. Orders received before the designated cut-off time will be sent with the Facility's regular scheduled delivery. STAT delivery may be requested in between scheduled deliveries for urgent medication needs not available in the On-Site stores provided by the pharmacy after fax cut-off times for scheduled deliveries. The pharmacist will determine if the medication will be dispensed from Remedi or whether it will be dispensed from a local, back-up pharmacy. Review of the policy: Medication Administration (dated 06/21/17) revealed medications were to be administered by legally authorized and trained persons in accordance to applicable state, local and federal laws and consistent with accepted standards of practice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to maintain adequate infection control practices during the administration of medications. This affected two residents (#35 and #51) of three residents observed for medication administration. Findings include: Medical record review revealed Resident #35 was admitted on [DATE] and Resident #51 was admitted on [DATE]. On 07/29/25 between 8:48 A.M. and 9:15 A.M., observation of both Resident #35 and #51's morning medication administrations revealed Registered Nurse (RN) #200 would apply gloves, open the medication cart, removed the pharmacy package and over-the-counter bottles of the ordered medications from multiple drawers on the medication cart and then dispense the medications into his gloved hand. The medications would then be placed into the medication cup. Twice during the observations, RN #200 was observed opening the lid to the trash can to dispose of a wasted medication and throw away trash. The electronic keyboard was used to document the medication, the cart was locked and RN #200 entered the resident room wearing the same gloved hands. The medications were administered to the residents. RN #200 would then remove his gloves, throw them in the trash in the residents room and used hand sanitizer. On 07/29/25 at 4:59 P.M., interview with RN #200 verified the above. Review of the policy: Glove Technique - Clean (revised April 2002) revealed don clean gloves whenever you may come in contact with blood, urine or feces. Wash hands each time gloves are removed. Review of the policy: Hand Hygiene (revised 11/28/17) revealed staff should perform hand hygiene even if gloves were used before and after contact with the resident, after contact with blood, body fluids or visibly contaminated surfaces or other objects and surfaces in the resident's environment.		