STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365687	A. Building B. Wing	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Marietta	400 Seventh 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, observation, review of a facility self-reported incident (SRI) and facility investigation, facility policy review, and interview, the facility failed to ensure residents were free from sexual abuse when Resident #1 was sexually abused by Resident #2. This affected one (Resident #1) of three residents reviewed for sexual abuse. Actual physical and/or psychosocial harm occurred, applying the reasonable person concept, on 12/30/22 to Resident #1, a resident with impaired cognition and communication, when Resident #2 was found fondling the resident's breast. Findings include: Review of the medical record for the Resident #1 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, psychosis, major depressive disorder, dysphagia, muscle weakness, difficulty walking, and macular degeneration. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/04/22, revealed Resident #1 had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, toileting, and personal hygiene. Review of the resident's behaviors revealed delusions and the rejection of care. Review of a Self-Reported Incident (SRI), tracking number 230623, dated 12/30/22 at 9:26 A.M., revealed the facility reported an incident of sexual abuse involving Resident #1 and Resident #2. The SRI noted Resident #1's diagnoses included Alzheimer's disease with late onset and Resident #2's diagnoses included dementia with agitation and schizoaffective disorder with a traumatic brain injury. The incident occurred on 12/30/22 at 6:50 A.M., in the dining room, when Resident #2 was observed with his hand down Resident #1's shirt. The residents were immediately separated, and Resident #2 was placed on one-to-one observation. Observation of Resident #2 was started on 12/30/22 at 7:00 A.M. and continued every 15 minutes until 01/02/23. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a social services progress note, dated 12/30/22 at 10:26 A.M., revealed Resident #1 was interviewed after a report of peer-to-peer contact. The resident had a Brief Interview for Mental Status (BIMS) score of 0 (cognitive impairment). The note revealed the resident had no increased anxiety, emotional distress, or depression reported by the staff or the resident. The resident did not recall the occurrence and staff stated the resident did not appear to understand or be bothered when the incident occurred. When asked if she felt safe in the facility, the resident began reciting illogical and irrelevant topics that were difficult to follow. The resident spoke of someone moving to a new location and asked if they had passed. The subject then changed to the resident going to the store for her arm. Review of a nurse progress note, dated 12/30/22 at 11:02 A.M., revealed Resident #1 did not remember the incident and stated she felt safe in the environment. A skin check was completed. The resident denied pain, and the physician and responsible party were notified. Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of cerebrum, traumatic subdural hemorrhage, aphasia, dementia, schizoaffective disorder, seizures, and muscle weakness. The resident was discharged from the facility on 01/09/23. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/21/22, revealed the resident had severely impaired cognition. The resident required extensive assistance of two staff for bed mobility, transfers, toileting, and personal hygiene. Review of the resident's behaviors revealed delusions, physical behaviors directed to others and other behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, screaming, and disruptive sounds. Review of Resident #2's physician order, dated 03/02/22, revealed the order to monitor behaviors, every shift, for urinating in inappropriate areas, tearfulness, delusions, taking other's drinks, hitting other residents, turning lights on and off, exposing self in hallway, wandering in and out of other's rooms, exiting, restlessness, being combative with staff, sleeplessness, pushing other residents in their wheelchairs, and for shutting other's doors. Review of a social services progress note, dated 12/30/22 at 12:33 P.M., revealed it was reported Resident #2 was involved in inappropriate resident-to-resident contact. The resident's BIMS score was 3. There was no increased anxiety or depression reported. Resident #2 stated he felt safe in the facility. The resident could not recall the earlier incident. Staff were interviewed and reported the resident said he thought Resident #1 was his grandmother. Staff reported a significant increase in sexual behaviors for Resident #2 during the past 14 days which included standing directly behind staff members and attempting to grab their waists, but with no body-to-body contact. The resident was resistant to redirection with less physical aggression noted but with more verbal outbursts reported. Review of the facility investigation, dated 12/30/22, revealed all residents residing on the memory care unit were assessed for skin impairment or injury and staff interviews were conducted. On 12/30/22, a referral was made for Resident #2 to be discharged to an all-male behavioral unit. The facility completed their investigation on 01/06/23 at 3:02 P.M. and substantiated the allegation of abuse. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of State-tested Nurse Aide (STNA) #100's witness statement, dated 12/30/22, revealed STNA #100 came into the dining room and observed Resident #2 with his hand down the left side of Resident #1's shirt and rubbing her breast. STNA #100 asked Resident #2, why did you do this? Resident #2 stated, because she likes it. Review of Registered Nurse (RN) #105's witness statement, dated 12/30/22 at 6:50 A.M., revealed RN #105 was informed by STNA #100 of Resident #2 fondling Resident #1's left breast. The residents were separated, Resident #1 was taken to her room and a skin sweep was conducted with no concerns. During interview on 01/11/23 at 10:48 A.M., the Director of Nursing (DON) confirmed the facility investigation did substantiate the allegation of sexual abuse between Resident #1 and Resident #2. During observation on 01/11/23 at 11:10 A.M., Resident #1 was sitting in her wheelchair, in the dining room of the memory care unit. The resident was smiling and holding a baby doll. The resident only smiled and did not answer any questions. Resident #2 was discharged from the facility and was unable to be observed or interviewed. Interview on 01/11/23 at 11:15 A.M., STNA #100 revealed she walked into the dining room of the memory care unit and observed Resident #1 sitting in her wheelchair, in the middle of the room. Resident #2 was standing behind Resident #1's wheelchair with his back toward the door. STNA #100 stated Resident #2's hand was down Resident #1's shirt, on the left side of her body. STNA #100 stated she asked Resident #2 what he was doing, and he replied, nothing much, which was his usual response when asked a question. STNA #100 revealed she took Resident #2 aside and asked again, what were you doing. The resident stated, I was playing with her nipple because she likes it. STNA #100 revealed she asked Resident #2 if he knew who the other resident was, and he said Resident #1 was his grandmother. STNA #100 revealed the residents were separated and she notified RN #105 of the incident. Resident #2 was placed on one-to-one observation. STNA #100 confirmed there was no staff member in the dining room at the time of the incident. Reviewed facility policy, Abuse, Neglect, and Misappropriation, dated 07/28/20, revealed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Investigation of Alleged Abuse: an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation. Written procedures for investigations include identifying staff responsible for the investigation; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to responding immediately to protect the alleged victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increase supervision of the alleged victim and residents; room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. This deficiency represents non-compliance investigated under Master Complaint Number OH00139296, Self Reported Incident Control Number OH00139364, and Self Reported Incident Control Number OH00139182.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, review of a facility self-reported incident (SRI), facility investigation, employee personnel file review, facility policy review, and interview, the facility failed to ensure residents were free from misappropriation of medications. This affected one (Resident #4) of three residents reviewed for misappropriation. Findings include: Review of the medical record for the Resident #4 revealed an admitted [DATE]. Diagnoses included schizophrenia, dementia, anxiety disorder, alcoholic cirrhosis of the liver, chronic kidney disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/28/22, revealed the resident had intact cognition. The resident required extensive assistance of two staff for transfers, and extensive assistance of one staff for toileting and personal hygiene. Review of the resident's behaviors revealed no psychosis or rejection of care. Review of Resident #4's physician order, dated 12/21/22, revealed the order for Clindamycin HCL (antibiotic) capsule, give 450 milligrams (mg) three times per day, for seven days, for methicillin-resistant staphylococcus aureus (MRSA). Review of the Self-Reported Incident (SRI) #230910, dated 01/09/23 at 5:47 P.M., revealed on 01/09/23 at approximately 3:30 P.M., the Director of Nursing (DON) was notified by staff of a possible misappropriation of a discontinued medication belonging to Resident #4. The alleged nurse, Licensed Practical Nurse (LPN) #115, was immediately suspended pending the investigation. Review of the medical records revealed Resident #4 did receive the scheduled doses of medication. During interview with LPN #115, she revealed that she did take Resident #4's remaining clindamycin medication which was to be returned to the pharmacy. Review of the facility investigation, dated 01/09/23, revealed the DON and the Administrator interviewed LPN #115 regarding the allegation of misappropriation of Resident #4's clindamycin medication. The DON asked LPN #115 if she was aware of the incident involving the clindamycin and LPN #115 stated, I thought it would be thrown away, so I took them because I had a toothache. I never actually took the pills. I still have them with me, I can return them. LPN #115 was suspended immediately pending the investigation. The facility completed their investigation on 01/11/23 at 12:59 P.M. and substantiated the allegation of misappropriation. Review of State-tested Nurse Aide (STNA) #114's witness statement, dated 01/09/23, revealed she was working on the first floor when she observed LPN #115 take some medications out of the medication room. According to the witness statement, LPN #115 sat at the desk and removed the medications from the packaging, placed them into a cup, and then placed the cup into her bag and went upstairs. LPN #115 placed the empty packaging into the garbage can. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN #116's witness statement, dated 01/09/23 at 4:10 P.M., revealed LPN #115 was observed taking Clindamycin 150 milligrams (mg) from the medication room and then popping them out of the card and into a cup, to reportedly take for a toothache. Review of LPN #115's personnel record revealed she was terminated from employment on 01/11/23 due to misappropriation of medication. During interview on 01/11/23 at 10:48 A.M., the Director of Nursing (DON) confirmed LPN #115 misappropriated Resident #4's remaining clindamycin medication. Reviewed facility policy, Abuse, Neglect, and Misappropriation, dated 07/28/20, revealed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Investigation of Alleged Abuse: an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation. Written procedures for investigations include identifying staff responsible for the investigation; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to responding immediately to protect the alleged victim and integrity of the investigation; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; increase supervision of the alleged victim and residents; room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. This deficiency is cited as an incidental finding to Master Complaint Number OH00139296.