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	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, review of a Self-Reported Incident, policy review and interview, the facility failed to treat residents with dignity and respect. This affected one resident (Resident #2) of three residents reviewed for dignity. The facility census was 37.Findings include: Review of the medical record for Resident #2 revealed an admission date of 06/26/25. Diagnoses included end stage renal disease, cognitive communication deficit, atherosclerotic heart disease, paroxysmal atrial fibrillation, type two diabetes with diabetic polyneuropathy, peripheral vascular disease, non-pressure chronic ulcer of the left foot, chronic non-pressure ulcer of the right foot and other encephalopathy. Review of a care plan for Resident #2, dated 03/26/26, revealed a focus of care for cognitive impairment related to cognitive communication deficit. Interventions included anticipating needs and meeting them promptly.Review of Self Reported Incident (SRI) Tracking Number 273294, dated 04/14/26, revealed the facility investigated an incident of staff abuse of a resident. Resident #2 reported to the Administrator on 04/14/26 that Dietary Aide (DA) #207 had thrown a pan at her over the weekend. The report indicated a thorough investigation had occurred as well as education, and the allegation was unsubstantiated. On 04/29/26 at 11:30 A.M., an interview with Dietary Manager #222 revealed she had reviewed the incident of reported abuse of Resident #2. She reported Resident #2 was non-compliant and on a renal diet. DA #207 just tells it like it is to Resident #2. If that was what her diet ticket said, that was what she got, and we weren't making no exceptions for her. The dietary manager thought the resident was vindictive and said whatever she had to in order to get DA #207 in trouble. She reported DA #207 had a brisk mouth but didn't do anything wrong.On 04/29/26 at 11:35 A.M., an interview with DA #224 revealed she did not think a pan or anything else had actually been thrown at the resident, however DA #207 had thrown a package of rolls at her and Resident #2 witnessed this and made the allegation.DA #224 stated she was afraid to work with DA #207 and refused to work with her any longer. She reported DA #207 had been suspended for a couple days while the facility investigated the alleged incident, but she was allowed to come back to work. She stated DA #207 was rude to Resident #2 all of the time, but also felt she was rude to everyone. DA #224 was legally blind, and DA #207 would slam things down on the counter and yell things at her like can't you read what that says? and this would embarrass her.On 04/29/26 at 11:59 A.M., an interview with Resident #2 revealed she had gone to the kitchen to check the menu for the evening. The old lady (referencing DA #207) in the kitchen was rude and said, what do you want now? when Resident #2 went to the kitchen. The next thing she knew, the woman threw a pan at her. She reported she told the woman she was a danger to every resident in the facility acting like that. She had not been interviewed by anyone from the facility since reporting the situation to the administrator. The resident stated the DA went on a family leave for a few days and everything was smooth and peaceful. Resident #2 reported she felt afraid of DA #207 because DA #207 did not treat her respectfully On 04/30/26 at 2:00 P.M., an interview with the Administrator revealed he had not personally investigated an incident of abuse reported as SRI #273294 on 04/14/26 but DA #207 was a really sweet lady. He did think it was more of a Human Resources issue with DA #207, and she was allowed to return to work with no interventions, no disciplinary action, and no further investigation, which the (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator felt he needed to do, but I just have not had the time.Review of a facility policy titled Dignity, dated 2001, revealed each resident would be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The policy indicated residents would be treated with dignity and respect at all times. Residents would be able to exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with the facility. Staff would always speak respectfully to residents, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his room number, diagnosis or care needs. Staff were expected to treat cognitively impaired residents with dignity and sensitivity including addressing the underlying motives or root causes for behavior and not challenging or contradicting the resident's beliefs or statements.This deficiency represents non-compliance investigated under Complaint Number 2968896.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post, in a place readily accessible to residents and family members and legal representatives of residents, the results of the most recent survey of the facility, which included any surveys, certifications, and complaint investigations made during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request. This affected all residents of the facility. The facility census was 37.Findings include:On 04/27/26 at 10:30 A.M., an observation of the facility survey book, located in the main lobby on a table top, did not contain the survey results (2567) from the 03/09/26 survey or the plan of correction for the survey. On 04/27/26 at 10:34 A.M., an interview with the Administrator verified he had not placed the 2567 (the survey results and/or the plan of correction) into the facility survey book from the most recent survey dated 03/09/26. This deficiency represents non-compliance investigated under Complaint Number 2968896.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to protect the privacy of personal records of all residents by storing medical records in an unlocked, open resident room in the facility which could be accessed at all times. This had the potential to affect all residents. The facility census was 37.Findings include: On 04/27/26 at 9:44 A.M., an observation of room [ROOM NUMBER] revealed two hospital beds and a table in the middle. Each surface was covered with resident records. The door was open and unlocked. This was confirmed by the administrator during interview on 04/27/26 at 10:22 A.M. On 04/27/26 at 10:18 A.M., an interview with Licensed Practical Nurse (LPN) #256 revealed the 100 hall was formerly the memory care unit. Since the unit had been closed, the doors to the unit were never locked. This was confirmed by the administrator during interview on 04/27/26 at 10:34 A.M. On 04/27/26 at 10:20 A.M., an observation of room [ROOM NUMBER] revealed a room with the door wide open. There was a box on the floor with an open binder containing medical records including covid vaccination information lying on top of the box. This was confirmed by the administrator during interview on 04/27/26 at 10:34 A.M. On 04/27/26 at 10:34 A.M., an interview with the Administrator revealed his expectation for medical records was they be stored in a room not easily accessible by residents. He reported the facility had a room in the 400-hall dedicated to medical records and the medical records were managed by Medical Records (MR) #230. The administrator further confirmed room [ROOM NUMBER] and 112 both contained resident medical records. Both rooms had the doors to entry unlocked and open. Records in room [ROOM NUMBER] contained records for an active resident of the facility. He indicated the facility just did not have enough storage space. He would make sure something was done with these records as soon as possible. On 04/27/26 at 11:41 A.M., an interview with Medical Records Director (MRD) #230. When something needed to be uploaded to the electronic medical record, it would be placed in his box by nursing, then scanned into the resident file. The facility kept Do Not Resuscitate Forms, informed consent, or things we may need to access with a power outage in a paper file once scanned. Paper files were kept in the Medical Records office. To his knowledge, there were no other medical records kept anywhere else in the facility. He knew through the company they were required to keep any records for seven years. Anything beyond seven years, he was advised he could shred the files. He knew medical records needed to be stored behind a locked door. Review of an undated facility policy titled Location and Storage of Medical Records version 2.0 revealed the facility would protect and safeguard all medical records. All medical records for current residents were kept electronically. Any records which were not electronic would be filed in the Medical Records Department. All medical records were maintained by the Medical Records Director/Assistant. When a resident was discharged , all paper medical records for the resident would be uploaded to the Electronic Health Record (EHR) within 30 days of discharge from the facility. Medical Records older than 36 months would be kept according to the Medical Record Retention policy. Medical records were to be stored in a locked room and protected from fire, water damage, insects, and theft. This deficiency represents non-compliance investigated under Complaint Number 2968896.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, review of a self-reported incident and interview, the facility failed to thoroughly investigation an allegation of staff to resident abuse. This affected one resident (#2) of three residents reviewed for abuse. The facility census was 37. Findings include:Review of the medical record for Resident #2 revealed an admission date of 06/26/25. Diagnoses included end stage renal disease, cognitive communication deficit, atherosclerotic heart disease, paroxysmal atrial fibrillation, type two diabetes with diabetic polyneuropathy, peripheral vascular disease, non-pressure chronic ulcer of the left foot, chronic non-pressure ulcer of the right foot and other encephalopathy. Review of a care plan for Resident #2, dated 03/26/26, revealed a focus of care for cognitive impairment related to cognitive communication deficit. Interventions included anticipating needs and meeting them promptly.Review of Self Reported Incident (SRI) Tracking Number 273294, dated 04/14/26, revealed the facility investigated an incident of staff abuse of a resident. Resident #2 reported to the Administrator on 04/14/26 that Dietary Aide (DA) #207 had thrown a pan at her over the weekend. The report indicated a thorough investigation had occurred as well as education, and the allegation was unsubstantiated. On 04/29/26 at 11:30 A.M., an interview with Dietary Manager #222 revealed she had reviewed the incident of reported abuse of Resident #2. She reported Resident #2 was non-compliant and on a renal diet. DA #207 just tells it like it is to Resident #2. If that was what her diet ticket said, that was what she got, and we weren't making no exceptions for her. The dietary manager thought the resident was vindictive and said whatever she had to in order to get DA #207 in trouble. She reported DA #207 had a brisk mouth but didn't do anything wrong.On 04/29/26 at 11:35 A.M., an interview with DA #224 revealed she did not think a pan or anything else had actually been thrown at the resident, however DA #207 had thrown a package of rolls at her and Resident #2 witnessed this and made the allegation. DA #224 stated she was afraid to work with DA #207 and refused to work with her any longer. She reported DA #207 had been suspended for a couple days while the facility investigated the alleged incident, but she was allowed to come back to work. She stated DA #207 was rude to Resident #2 all of the time, but also felt she was rude to everyone. DA #224 was legally blind, and DA #207 would slam things down on the counter and yell things at her like can't you read what that says? and this would embarrass her.On 04/29/26 at 11:59 A.M., an interview with Resident #2 revealed she had gone to the kitchen to check the menu for the evening. The old lady (referencing DA #207) in the kitchen was rude and said, what do you want now? when Resident #2 went to the kitchen. The next thing she knew, the woman threw a pan at her. She reported she told the woman she was a danger to every resident in the facility acting like that. She had not been interviewed by anyone from the facility since reporting the situation to the administrator. The resident stated the DA went on a family leave for a few days and everything was smooth and peaceful. Resident #2 reported she felt afraid of DA #207 because DA #207 did not treat her respectfully.On 04/30/26 at 2:00 P.M., an interview with the Administrator revealed he had not personally investigated an incident of abuse reported in SRI #273294 on 04/14/26. He had Dietary Manager (DM) #222 review the incident and do interviews with staff. He confirmed no interviews or witness statements were included with the investigation of the self-reported incident and he thought the DM still had them. Further, he indicated he did not believe all staff who were present when the incident occurred had been interviewed. The Administrator stated he felt he had the statements for the alleged incident investigation but after searching, he verified he was unable to locate statements for the investigation. Review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investing dated 2001 revealed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. All allegations are thoroughly investigated and initiated by the administrator. The investigation may be assigned to an individual trained in reviewing, investigating (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reporting such allegations.This deficiency is an incidental finding discovered during the complaint investigation.

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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 record review, interview, and policy review, the facility failed to ensure a fall intervention was implemented immediately after a fall. This affected one resident (Resident #78) of three residents reviewed for accidents. The facility census was 37. Findings include:Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, dementia, morbid obesity, coronary artery heart disease, and chronic obstructive sleep apnea.Review of the Care Plan revised on 04/20/26 revealed Resident #78 was at risk for falls with interventions including to encourage the resident to ask for assistance with all transfers, to wear non-skid footwear, and to use his walker for ambulation. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/24/26, revealed Resident #78 had intact cognition and required staff assistance with activities of daily living.Review of a nursing progress note dated 04/25/26 at 5:37 A.M. revealed Resident #78 was found sitting on the floor in his room by a certified nursing assistant (CNA). The CNA notified the nurse who assessed Resident #78 and performed neurological checks. The medical provider was notified and with orders to continue to monitor. Further review of the nursing progress note revealed no documentation or evidence of an immediate fall intervention implemented following the fall.Review of the fall investigation dated 04/25/26 revealed no documentation or evidence of an immediate fall intervention implemented following the fall. Further review of care plan revealed no new fall interventions following the most recent fall on 04/25/26.Review of the Interdisciplinary Team (IDT) progress noted dated 04/30/26 at 4:22 P.M. revealed the IDT met to review Resident #78's incident. Resident attempted to stand beside bed to use urinal. While attempting to stand, resident's foot slipped, which ultimately resulted in a fall. New intervention for grip strips to left side of bed to prevent further occurrences.Interview on 05/06/26 at 3:49 P.M. with Director of Nursing confirmed a new fall intervention was not implemented timely following Resident #78's fall on 04/25/26. The DON further confirmed that a new fall intervention was not implemented until the IDT met on 04/30/26 and implemented the new intervention for grip strips to the left side of the bed to prevent further occurrences. Review of the facility's policy titled, Managing Falls and Fall Risk, undated, revealed staff will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation Add a residence of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff will implement additional interventions or different interventions or indicate why the current approach remains relevant. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling.This deficiency represents noncompliance identified under Complaint Number 2970501.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, Employee Counseling Form review and interview, the facility failed to maintain complete and accurate medical records. This affected two (Resident #84 and Resident #78) of three residents reviewed for accurate medical records. The facility census was 37.Findings include: 1.Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, dementia, morbid obesity, coronary artery heart disease, and chronic obstructive sleep apnea.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/24/26, revealed Resident #78 had intact cognition and required staff assistance with activities of daily living.Review of Resident #78's 4PLEX RSV laboratory test dated 04/24/26 revealed a positive result. Review of the Infection Control Log, dated April 2026, revealed Resident #78 tested positive for RSV on 04/27/26.Interview on 04/30/26 at 3:27 P.M. with Infection Preventionist (IP) #256 stated that she became aware of Resident #78's RSV positive test result on 04/27/26 when she reviewed labs on Monday and realized LPN #213 misread Resident #78's RSV lab result dated 04/24/26 as negative. IP #256 confirmed she did not revise the infection control log with Resident #78's correct RSV positive test date. Interview on 04/30/26 at 3:37 P.M. with LPN #213 revealed she incorrectly read Resident #78's RSV lab test result as negative and charted this incorrectly. LPN #213 stated she had no idea that Resident #78 was RSV positive until 04/27/26 when she was notified by IP #256.Interview on 05/06/26 at 3:50 P.M. with the Director of Nursing confirmed the Infection Control Log was inaccurate and did not reflect Resident #78's correct RSV positive lab result. 2. Medical record review revealed Resident #84 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, pulmonary embolism, atrial fibrillation, congestive heart failure (CHF), chronic kidney disease, diabetes mellitus, cognitive communication disorder, and anxiety disorder. Review of Resident #84's Care Plan, initiated on 03/30/26, revealed the resident has altered cardiovascular status related to CHF with interventions including assessing for shortness of breath and cyanosis every shift, monitor/document/report to physician changes in lung sounds on auscultation, edema, and changes in weight.Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 04/09/26, revealed Resident #84 had moderately impaired cognition and required staff assistance with activities of daily living.Review of a physician order dated 04/21/26 revealed the order to obtain a daily weight due to congestive heart failure (CHF): notify physician of weight gain or loss of 3 pounds (lbs.) in one day or 5 lbs. in one week.Review of the 4PLEX RSV laboratory test dated 04/22/26 revealed a positive result.Review of Resident #84's Weight Summary revealed a weight of 112.0 on 04/24/26, no recorded weight on 04/25/26, and a weight of 117.4 on 04/26/26. Review of the medical record revealed no evidence of physician notification following the 5.4 lb. weight gain on 04/26/26.Review of a nursing progress note dated 04/25/26 at 6:23 A.M. revealed the resident refused to be weighed for CHF monitoring. Review of the medical record revealed no evidence of physician notification of Resident #84's weight refusal. Review of a nursing progress note dated 04/25/26 at 7:05 P.M. revealed the resident refused to be weighed for CHF monitoring. Review of the medical record revealed no evidence of physician notification of Resident #84's weight refusal. During first review of the nursing progress notes, there was no evidence of physician notification of Resident #84's refusal to be weighed on 04/25/26. Subsequent review revealed a late entry nursing progress note created on 04/29/26 at 12:38 P.M. (authored by the DON) with the effective date of 04/27/26 at 12:37 P.M. and a follow-up to the nursing progress note dated 04/25/26 at 7:05 P.M (authored by LPN #902). The newly created note revealed the Medical Doctor and Resident Representative were notified of refusals.Interview on 04/29/26 at 4:24 P.M. with LPN #902 revealed she did not recall notifying the physician or the family representative of Resident #84's refusal to be weighed on 04/25/26. LPN #902 stated she always (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented notifications in her nursing notes. LPN #902 confirmed that she had not been contacted by the DON to verify if the physician had been notified.Interview on 04/29/26 at 2:00 P.M. with the DON confirmed the physician was not notified of Resident #84's refusal to be weighed as ordered and was not notified of the resident's weight gain of 5.4 lbs. from 04/24/26 through 04/26/26. The DON confirmed that she entered the late entry progress note on 04/29/26 at 12:38 P.M. as a follow-up to the nursing progress note dated 04/25/26 at 7:05 P.M authored by LPN #902 because she mistakenly thought the on-call physician had been notified. The DON confirmed that she had no evidence of the physician notification prior to charting incorrect information in Resident #84's nursing progress note on 04/29/26 at 12:38 P.M.Interview with the Administrator on 04/29/26 at 4:57 P.M. with Administrator stated after reviewing emails to the on-call service for the date of 04/25/26, it was determined there was no communication between LPN #902 and the on-call physician service related to Resident #84's refusal of a weight or any other refusals as stated by the DON. The Administrator further stated the DON was counseled regarding inaccurately recording information in Resident #84's medical record. Review of the Employee Counseling Form, dated 04/29/26, provided by the Administrator, revealed the DON received a verbal warning related to adding a late entry nursing progress note without confirming such notification with the staff member on duty at the time that the notification occurred and for not ensuring the medical record was complete and reflective of the care provided. The corrective action plan revealed the DON would be audited on the importance of validating that items are 100% complete in the medical record before adding any additions.Review of the facility's policy titled, Change in a Resident's Condition or Status, undated revealed our facility promptly notifies the resident, his or her physician, and the resent representative of changes in the resident's condition and/or status. The nurse will notify the resident's attending physician when there has been a significant change in the resident's physical /emotional/mental condition, or specific instruction to notify the physician or changes in the resident's condition. This deficiency represents noncompliance investigated under Complaint Number 2970501.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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, infection control log review, review of local health department guidance, Center for Disease Control information review, review of text message communication, nursing staff schedule review, facility policy review and interview, the facility failed to develop and implement a comprehensive infection control program that included prevention, identification, investigation and reporting of communicable disease including Respiratory Syncytial Virus (RSV) infection. This resulted in Immediate Jeopardy and the likelihood of serious harm, complications and/or death for all 37 residents beginning on [DATE] when staff (Licensed Practical Nurse (LPN) #251) worked providing care to residents despite positive RSV test results and subsequently, a second staff (Certified Nursing Assistant (CNA) #237) was positive for RSV and worked (on [DATE]). Additionally, Actual Harm occurred on [DATE] when Resident #3 expired in the facility with RSV noted as a significant condition on the resident's death certificate. Despite known positive test results and symptoms, the facility Director of Nursing permitted staff to work with residents promoting resident exposure. The facility did not timely identify an RSV outbreak, investigate potential sources of the infection, implement timely and appropriate interventions to prevent the spread of RSV including isolation of symptomatic residents, prevent the co-horting of positive and negative residents, monitor residents for onset of symptoms or exacerbation of symptoms, timely report the outbreak to the local health department or ensure staff education to reduce the spread of infection to the highest extent possible. This affected six residents (#3, #20, #64, #66, #78, and #84) who contracted RSV while residing in the facility and had the potential to affect all 37 residents. On [DATE] at 1:13 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when the facility failed to ensure symptomatic and RSV positive staff, Licensed Practical Nurse (LPN) #251, was not permitted to work resulting in exposure to residents and other staff and failed to have a comprehensive and effective infection control program which resulted in the transmission of RSV among residents in the facility, across two units resulting in six residents (#3, #20, #64, #66, #78 and #84) contracting RSV; a 16.2% infection rate with no evidence the facility timely identified the outbreak or implemented appropriate and sustainable interventions to prevent the spread of the communicable disease. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] following an internal review of the events described above and in conjunction with an ongoing survey, the facility initiated a comprehensive, multi-pronged response to address both the active outbreak and the underlying systemic gaps that contributed to it. The facility identified the potential trigger for the outbreak was staff attending work with symptoms and not reporting positive test results or being permitted to work despite positive test results and a physician slip to be off work. On [DATE] at 3:00 P.M. the Regional Director of Clinical Services (RDCS) RN #402 and Regional Assistant Director of Clinical Services RN #404 provided targeted re-education to the facility Clinical Managers. The training was regarding RSV-specific precautions and the critical importance of following current CDC guidance in the management of contagious respiratory illness in the skilled nursing facility setting. A total of five (5) clinical leadership staff (Infection Preventionist #256, RN #204, LPN Manager #266, Minimum Data Set (MDS)/RN #259, and the DON) received the training. All five individuals receiving the education were required to complete a post-test, with any missed questions resulting in individualized re-education and re-testing until a score of 100% was achieved. To ensure clinical leadership adherence to the corrective action plan going forward, the Regional Director of Clinical Services RN #402 would conduct direct oversight and accountability check-ins with the DON and clinical managers. Any future deviation from the corrective action plan, including permitting a staff member with a positive test result and a physician's written work restriction to work would result in progressive disciplinary action up to and including termination. This expectation was communicated directly to the DON and (continued on next page)

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	365780	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Heights Post Acute	5001 State Route 60 Marietta, OH 45750

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	was documented in her personnel file On [DATE] at 4:00 P.M. the DON/Designee initiated a house-wide clinical assessment of all 37 current residents in the facility to identify any individuals with active signs or symptoms consistent with RSV or another communicable respiratory illness. Any symptomatic resident identified during this review was immediately prioritized for testing per physician order, placed on appropriate isolation precautions, and had their treating provider and responsible party notified without delay. No residents were identified on this date of being symptomatic for RSV. On [DATE] at approximately 4:30 P.M. the DON/designee also initiated direct outreach to all current 70 staff members to assess whether any employee was experiencing active signs or symptoms of RSV via telephone and in person interviews. Staff members reporting symptoms were directed to obtain RSV testing, to report their results to the facility prior to returning to work, and to remain on work restriction until their symptoms had fully resolved and they had been afebrile for a minimum of 24 hours without the use of any antipyretic (fever reducing) medication. Clearance to return was designated as a clinical leadership determination requiring confirmation from the DON or Infection Preventionist. The current staff were re-educated that any respiratory-related illness symptoms or positive RSV tests should be forwarded to the DON or the Infection Preventionist to enable the clinical managers listed above to communicate CDC guided work restrictions and return to work criteria. Subsequently, CNA #242 was identified with symptoms of communicable disease on [DATE]. The CNA was directed to get tested, and she was notified that she would be removed from the schedule until she had provided negative test results to the DON or the Infection Preventionist. CNA #242 reported proof of negative results on [DATE] at 12:20 P.M. to the DON. The facility implemented a plan for new hired staff to receive this education as part of their formal orientation process and they would be required to sign the acknowledgment prior to working any shift at the facility. On [DATE], the DON/Designee concurrently provided education to facility staff via written education regarding the obligation to report any signs or symptoms of communicable respiratory illness including RSV, COVID-19, and influenza directly to the Infection Preventionist or Director of Nursing before entering the building or beginning any shift. Staff were additionally educated on the facility's return-to-work standards, the requirement that confirmed communicable illness diagnoses be reported to clinical leadership regardless of where or when the positive result was obtained, and the fact that return-to-work decisions must always be made by the DON or Infection Preventionist and may never be delegated to scheduling or non-clinical personnel. All staff completing this education were also required to pass a post-test, with the same re-education and re-test requirement applied to any missed questions. Staff members must complete this written education prior to working their next scheduled shift. Two as needed (PRN) staff have not completed the education. These staff are Physical Therapist #261 and Occupational Therapist #215. On [DATE] active surveillance which included monitoring symptoms, proactively communicating with staff and residents for any symptoms, and testing as needed was initiated. Daily symptom monitoring for all residents including a respiratory assessment. Beginning [DATE] the DON/Designee initiated weekly audits of a minimum of five residents and five staff members per week for four consecutive weeks, and as needed thereafter, to ensure residents were free from unaddressed signs or symptoms of RSV or other communicable respiratory illness, and that staff members understood and were consistently adhering to the facility expectations regarding illness reporting and return-to-work requirements. It was the facility's expectation that staff members communicate any suspected illnesses directly with the DON or the Infection Preventionist immediately for further guidance. Any issues identified within the audits are to be forwarded to the QA Committee for immediate follow-up and review. On [DATE] at 11:29 A.M. the facility spoke with the medical director, Physician (MD) #406 related to the facility initial action plan related to the RSV outbreak and current Quality Assessment and Performance Improvement (QAPI) plan in place. MD #406 agreed and indicated he would like to further review in detail when he came to the facility on [DATE]. On [DATE], the facility's RSV policy was formally revised (Version 2.0) to include specific outbreak action steps, employee health pathways, and isolation guidance. This was (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	was responsible for surveillance and reporting of infectious disease. Review of the policy revealed it was not specific to action planning, employee health pathways, or outbreak action steps. Review of the facility [DATE] Infection Control Log revealed the facility identified staff and residents who had tested positive for RSV: On [DATE] Licensed Practical Nurse (LPN) #251 was positive. On [DATE] Certified Nursing Assistant (CNA) #237 was positive. On [DATE] Resident #66 was positive. On [DATE] Resident #64 was positive (lab test dated [DATE]). On [DATE] Resident #3 was positive (lab test dated [DATE]). On [DATE] Resident #84 was positive. On [DATE] Resident #20 was positive.And on [DATE] Resident #78 was positive (lab test date [DATE]). On [DATE] at 2:47 P.M. interview with Infection Preventionist (IP) #256 confirmed six residents (#3, #20, #64, #66, #78, and #84) and two staff members LPN #251 and CNA #237 had each tested positive for RSV as noted above. IP #256 revealed the first RSV positive staff was LPN #251, who tested positive for RSV on [DATE]. IP #256 stated this LPN did not report symptoms or a positive RSV test to management. The second RSV positive staff member, CNA #237, tested positive on [DATE], and the first resident, Resident #66, tested positive on [DATE]. During the interview, IP #256 stated she was following Centers for Disease Control and Prevention (CDC) guidelines for RSV prevention but revealed the facility only had one policy regarding the prevention of RSV. On [DATE] at 2:50 P.M. interview with the Director of Nursing (DON) revealed the facility did not have a comprehensive policy in place related to RSV to timely identify, monitor, and treat residents. During the interview the DON revealed surveillance had not been implemented for all residents including monitoring for fever, cough, congestion, or a decline in function, nor had the facility monitored high-risk residents closely to ensure they did not have complications associated with RSV.On [DATE] at 11:16 A.M. interview with IP #256 revealed she had not initiated contact tracing, did not have a line list (a fundamental epidemiological tool used to track individual cases during an outbreak), and did not timely identify an outbreak of RSV until [DATE] when three additional residents (who were exposed in the facility) tested positive (the facility already had two positive staff members and one resident at this time). IP #256 further revealed communal gatherings of dining and group activities did not cease until [DATE], nor was the local health department notified of the situation until [DATE]. On [DATE] at 12:37 P.M. interview with County Health Department RN #407 revealed she was notified on [DATE] by IP #256 of five residents and two staff members testing positive for RSV. RN #407 stated she would have expected to be notified within 24 hours of an identified outbreak (two or more cases) and she was not. RN #407 stated following notification she emailed RSV guidance to IP #257.Review of the information provided to the facility from the local health department (LHD) following their notification on [DATE] revealed it contained a Viral Respiratory Pathogen Toolkit for Nursing Homes/Long Term Care Facilities dated [DATE] which provided information and guidance related to preventing the spread of respiratory viruses in nursing homes. RSV was listed as a respiratory virus for the toolkit. The information revealed a comprehensive approach that included not only vaccination, but also testing, prompt treatment, and the prompt implementation of proven infection prevention and control measures was required. Taken together, these actions could protect residents and staff from respiratory illness. Further review when an infection due to a respiratory virus was suspected in a resident or health care personnel (HCP), it was important to take rapid action to prevent the spread to others in the facility. Nursing home residents, including older adults, those who were medically fragile, and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of respiratory virus infection and may not have fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, or behavior changes. When an infection due to a respiratory virus was suspected in a resident or HCP, it was important to take rapid action to prevent the spread to others in the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 1:20 P.M. interview with Regional Director of Clinical Services RN #402 confirmed the facility only had a general policy related to RSV/respiratory infection, not a comprehensive policy or policy specific to RSV prevention, monitoring or the procedure for how to address cases of RSV and prevent the spread of the disease. On [DATE] at 1:45 P.M. interview with the DON revealed she did not realize there was an RSV outbreak until [DATE] when multiple residents were symptomatic and tested positive for RSV. The DON confirmed the facility failed to screen CNA #237 following her RSV positive test result and ongoing symptoms before permitting her to return to work and potentially spreading the RSV virus to other staff and residents. The DON further confirmed the facility did not have an effective RSV outbreak management plan in place. On [DATE] at 1:50 P.M. interview with the Administrator confirmed the RSV outbreak was not timely identified and the facility failed to have a comprehensive RSV outbreak management plan in place to prevent the spread of RSV to residents. The Administrator also verified the outbreak root cause was traced back to LPN #251 and CNA #237 both working despite their positive RSV tests. On [DATE] at 12:37 P.M. a follow-up interview with (County Health Department) RN #407 revealed for Class B or C respiratory outbreaks (which do not have a specific definition), the health department considers two cases of the illness in the facility occurring within a seven-day period an outbreak. Outbreak reporting was to occur in one business day. On [DATE] at 11:23 A.M. interview with Nurse Practitioner (NP) #405 revealed she had not been involved in the development of a facility RSV policy and procedure following the identification of the current RSV outbreak and could not speak to any facility RSV policy. NP #405 revealed she did not recall initially being notified of RSV positive staff and stated she first became aware of the situation when Resident #66 tested positive for RSV following a hospitalization. On [DATE] at 10:15 A.M. interview with Medical Director/Physician #406 revealed he had not been directly involved with any RSV policy or procedure development and was only initially notified of resident cases. He stated he was unaware staff were the first to test positive. Review of the Centers for Disease Control guidance for RSV isolation in long-term care facilities (LTCFs), per the Viral Respiratory Pathogens Toolkit for Nursing Homes, focus on prompt identification, using Transmission-Based Precautions (isolation) for symptomatic residents, and implementing source control (masking) to prevent spread. Symptomatic residents should be isolated, and in the event of an outbreak, facilities should implement enhanced measures such as co-horting residents and staff. When an infection due to a respiratory virus is suspected in a resident or health care personnel (HCP), it is important to take rapid action to prevent the spread to others in the facility.Nursing home residents, including older adults, those who are medically fragile, and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of respiratory virus infection and may not have fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, or behavior changes. When an infection due to a respiratory virus is suspected in a resident or HCP, it is important to take rapid action to prevent the spread to others in the facility. (continued on next page)

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