| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731<br><br>Based on observations, resident and staff interviews, medical record review, and policy review, the facility failed to ensure a resident who was dependent on staff for personal hygiene received adequate nail care. This affected one (Resident #78) of six residents reviewed for activities of daily living (ADLs). The facility census was 110.<br><br>Findings include:<br><br>Review of the medical record for Resident #78 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, type II diabetes mellitus, anxiety, schizophrenia, and major depressive disorder.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had intact cognition and was dependent on staff for personal hygiene. Resident #78 did not refuse care during the assessment period.<br><br>Review of the care plan dated 06/01/23 revealed Resident #78 had an ADL self-care performance deficit related to activity intolerance, disease process, fatigue, hemiplegia, impaired balance, and stroke. Interventions included to trim or clip nails weekly and as needed.<br><br>Review of the medical record dated 06/01/24 through 06/23/24 revealed no documentation of Resident #78 refusing care.<br><br>Observation and interview on 06/24/24 at 10:41 A.M. revealed Resident #78 had long fingernails, extending approximately three-fourth inches beyond the fingertip. Some fingernails had unidentifiable brown debris below the fingernail. Resident #78 stated his fingernails were long and he would like to have them trimmed.<br><br>Interview on 06/24/24 at 10:43 A.M. with the Director of Nursing (DON) confirmed Resident #78's fingernails were long and needed to be trimmed. The DON further stated Resident #78 refused staff assistance with care.<br><br>Observation and interview on 06/25/24 at 10:20 A.M. revealed Resident #78's fingernails remained long, untrimmed, and dirty underneath. Resident #78 stated nobody had offered to trim his fingernails and he still wanted them trimmed. Resident #78 denied refusing to have his nails trimmed.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 06/27/24 at 9:59 A.M. revealed Resident #78's fingernails remained long, untrimmed, and dirty.<br><br>Interview on 06/27/24 at 11:32 A.M. with State tested Nursing Assistant (STNA) #604 stated Resident #78 did not refuse care. STNA #604 stated Resident #78 was diabetic, so she asks the nurse to cut his fingernails.<br><br>Interview on 06/27/24 at 11:33 A.M. with Licensed Practical Nurse (LPN) #504 confirmed Resident #78's fingernails should be cut by the nurse since he was diabetic. LPN #504 further stated Resident #78 does not refuse care.<br><br>Review of the facility policy titled Activities of Daily Living, Supporting, dated 03/2018, revealed appropriate care and services will be provided for residents who are unable to care out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with items including nail care. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751<br><br>Based on observations, resident and staff interviews, medical record review, and review of the facility policy, the facility failed to ensure medications were not left at the bedside in a secured memory care unit. This affected one (Resident #9) of two residents reviewed for accidents. The facility identified 27 residents (#6, #10, #12, #13, #17, #20, #21, #23, #26, #30, #33, #37, #40, #44, #45, #52, #58, #66, #67, #72, #73, #81, #92, #93, #97, #99, and #100) who were cognitively impaired and independently mobile on the secured unit. The facility census was 110.<br><br>Findings include:<br><br>Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included convulsions, schizoaffective disorder, mood disorder, vascular dementia, major depressive disorder, personal history of traumatic brain injury, and hypertension.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact. Resident #9 required supervision/touching assistance for activities of daily living.<br><br>Review of the medication administration record (MAR) dated 06/24/24 revealed the following medications were due at 9:00 A.M. and signed out as administered by Licensed Practical Nurse (LPN) #614: Aspirin 81 milligrams (mg), Cymbalta 30 mg (depression), oxybutynin chloride ER (bladder) 5.0 mg, primidone 50 mg (tremors), divalproex 750 mg (convulsions), lovaza one gm (fish oil) give two capsules, metformin 500 mg (diabetes), Seroquel 25 mg (schizoaffective disorder) one half tablet, and multivitamin (supplement).<br><br>Review of the nursing note dated 06/24/24 at 11:20 A.M. revealed Resident #9 was given morning medication and was observed by writer putting medication in his mouth and grabbing his water bottle. About 15 minutes passed and the medication technician observed medications on the resident's table. Resident #9 apparently pocketed the medications in his cheek and put back in medication cup on bedside table after the nurse left the room.<br><br>Observation on 06/24/24 at 10:33 A.M. revealed Resident #9 had medications at the bedside. Resident #9 was not in the room. 10-11 pills were observed in the medication cup. Roommate was also not in the room. Subsequent observation on 06/24/24 at 10:36 A.M. revealed the medications observed in the medication cup did not appear to have been taken. Medications were dry and intact as well as no liquid noted in the medication cup.<br><br>Interview on 06/24/24 at 10:36 A.M. with Med Tech (MT) #700 verified medications were on the bedside table for Resident #9. MT #700 stated the resident went to activities. MT #700 took the medication cup from the room to the medication cart.<br><br>Interview on 06/25/24 at 2:03 P.M. with LPN #614 verified she gave Resident #9 his medications on 06/24/24. LPN #614 stated Resident #9 usually takes his medications with his water bottles and pops the pills in his mouth. LPN #614 stated she witnessed the resident put his medications in his mouth.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 06/26/24 at 7:52 A.M. with Resident #9 stated he takes his medications when they bring them to him. Resident #9 stated the nurses sometimes leave his medications on his table. Resident #9 denied ever pocketing or spitting out his medications. Resident #9 stated he just always takes them.<br><br>Review of the facility policy titled Administering Medications dated April 2019 revealed only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. Medications are administered within one hour of their prescribed time, unless otherwise specified. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication shall initial and circle the MAR space |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

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 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031<br><br>Based on medical record review and staff interview, the facility failed to timely act on pharmacy recommendations. This affected two (Residents #16 and #32) of five residents reviewed for unnecessary medications. The facility census was 110.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnosis included migraine.<br><br>Review of the document titled Note to Attending Physician/Prescriber dated 02/19/24 revealed a recommendation to include the phrase a maximum daily dose of 30 milligrams (mg) per 24 hours be added to the order for Rizatriptan Benzoate 10 mg tablet for migraine and give 10 mg by mouth every two as needed for migraine. May repeat after original dose in two hours as needed. The option of agree was indicated and the document was signed on 02/23/24.<br><br>Review of the medication administration record (MAR) and physician orders from 02/23/24 to 06/25/24 revealed the phrase a maximum daily dose of 30 milligrams (mg) per 24 hours had not been added to Resident #32's physician orders and MAR for Rizatriptan Benzoate.<br><br>Review of the document titled Note to Attending Physician/Prescriber dated 05/29/24 revealed the order for Diclofenac gel (treats pain and other symptoms of arthritis) does not have an amount to be applied. The document included a request to add the amount to be administered. The document indicated the Family Nurse Practitioner had agreed and was signed on 05/29/24.<br><br>Review of the second document titled Note to Attending Physician/Prescriber dated 05/29/24 revealed Resident #32 was receiving pain medications. Meloxicam 7.5 mg every 12 hours as needed for pain and Oxycodone 5.0 mg every eight hours as needed for severe pain. Neither of the medications had a pain scale to identify the level of pain indicating which pain medication should be administered.<br><br>Review of the MAR and physician orders from 05/29/24 to 06/25/24 revealed there was no dosage amount for Diclofenac gel and there was no pain level to identify which pain medication should be administered for Resident #32.<br><br>Interview on 06/26/24 at 1:49 P.M. with Regional Registered Nurse (RRN) #790 verified the pharmacy recommendations were not followed through for Resident #32.<br><br>45751<br><br>2. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included insomnia, low back pain, paranoid schizophrenia, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

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 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the pharmacy recommendation dated 12/22/23 revealed Resident #16 had the following pertinent medication order for Ibuprofen 600 milligrams (mg) by mouth one time a day every other day for headache. If appropriate would you trial a discontinuation of Ibuprofen. The physician agreed on 12/27/23.<br><br>Review of the physician orders from 12/27/23 to 06/26/24 revealed the Ibuprofen 600 mg was never discontinued for a trial period.<br><br>Review of the pharmacy recommendations dated 02/19/24 revealed Benadryl allergy oral tablet give two tablets by mouth at bedtime for sleep. Please consider alternative medication for sleep. The physician agreed on 02/23/24. The pharmacy recommendation dated 04/29/24 revealed in February a recommendation was made to consider an alternative to using Benadryl for sleep for this resident. The prescriber agreed (see recommendation sheet) but the resident still has an active order for Benadryl for sleep in the electronic medical record. Please follow up. The physician agreed.<br><br>Review of the physician orders from 02/19/24 to 05/11/24 revealed Benadryl was never discontinued and Resident #16 was administered Benadryl routinely. On 05/12/24, Benadryl was discontinued.<br><br>Interview on 06/27/24 at 10:44 A.M. with Regional Registered Nurse (RRN) #790 verified the physician initially agreed to the discontinuation of the ibuprofen on 12/27/23 but upon speaking with the resident, the physician changed her mind. RRN #790 verified the physician did not document this anywhere in Resident #16's medical record. RRN #790 verified the physician agreed to discontinue the Benadryl on 02/23/24 and 04/29/24 but the Benadryl was not discontinued until 05/12/24. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366238 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Norwood Towers Post-Acute | 1500 Sherman Avenue<br>Cincinnati, OH 45212 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>35031<br><br>Based on observation, staff interview, and policy review, the facility failed to ensure medications were stored in a proper and safe manner. This had the potential to affect all residents in the facility except the 40 residents residing on the secure unit. The facility census was 110.<br><br>Findings include:<br><br>1. Observation of the medication storage room on the third floor of the facility on 06/26/24 at 2:46 P.M. with Licensed Practical Nurse (LPN) #526 revealed the door was unlocked and accessible to anyone. The medication storage room had the following expired medications: two bottles of aspirin 81 milligrams (mg) with expiration date of 01/2024, a bottle of Senna plus with expiration date of 06/2024, but written in black ink on the bottle was 04/06/23. The inner seal had been removed. A bottle of stool softeners with expiration date of 08/2023. The room designated as the nurse's station on the third floor was unable to be locked. LPN #526 retrieved a grey plastic bag of medications from under the desk. The bag held numerous daily medication packs for the residents on the third floor for the next days doses. LPN #526 verified the door could not be locked and there were times no staff were in the room. LPN #526 verified the expired medications in the storage room.<br><br>2. Observation on 06/26/24 at 3:15 P.M. along with LPN #504 revealed a room on the lower level of the facility identified as central supply. The room was unlocked and contained numerous bottles of over-the-counter medications including aspirin 81 mg, aspirin 325 mg, acetaminophen 250 mg, stool softener 100 mg, and vitamins. LPN #504 verified the over-the-counter medications were stored in a unlocked room.<br><br>Review of the policy titled Storage of Medications revealed drugs and biological used in the facility are stored in locked compartments. |