

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2026
NAME OF PROVIDER OR SUPPLIER  Twilight Gardens Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  196 W Main St Norwalk, OH 44857	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, and policy review the facility failed to notify a family member when a Resident (#22) was transferred to the hospital emergency department. This affected Resident #22 on two separate occasions. This had the ability to affect all residents. The facility census was 77. Findings include: Review of Resident #22's medical record revealed an admission date of 07/09/25. Diagnoses included chronic obstructive pulmonary disease, congestive heart failure, and chronic renal failure. Review of Resident #22's quarterly Minimum Data Set (MDS) dated [DATE] revealed she had a low cognitive function. Resident #22 was dependent on staff for activities of daily living. Review of Resident #22's most recent care plan revealed the resident had a behavior problem evidenced by being physically and verbally abusive toward staff and refusing treatments. Review of Resident #22's contact information revealed she was her own responsible party. Daughter #1 was the resident's first emergency contact and her authorized Health Insurance Portability and Accountability Act (HIPAA) contact. Daughter #2 was listed as another emergency contact. Review of Resident #22's Respiratory Therapy (RT) note dated 09/03/25 at 1:00 A.M. revealed the RT entered the resident's room for routine rounding. Resident #22 was on oxygen at six liters and her blood oxygen saturation level (SpO2) was 84 percent (%). The RT suctioned the with no improvement in oxygenation as Resident #22's SpO2 continued to drop and the resident exhibited intermittent jerking of the extremities, and was very drowsy. Resident #22 failed to respond to verbal stimuli and had minimal response to physical stimuli. The primary nurse was updated and was asked to come into the room and assess Resident #22. RT continue to suction via in-line catheter, was taken off the ventilator, and suctioned again. The resident's SpO2 dropped to between 74-85% so the decision was made to begin providing manual bag assisted ventilation, the ambu bag was hooked up to an oxygen tank at 15 liters. Resident #22 was bagged, lavaged, and suctioned which produced a large amount of thick cream colored mucus. Resident #22 was placed back on the ventilator as the resident's SpO2 was at 95%, but as soon as the resident was put back on the ventilator the resident's oxygen saturation started to decrease almost immediately so the staff went back to bagging, and called emergency medical services. When emergency medical services arrived, they took over ventilating the resident and transferred the resident to the hospital. Review of Resident #22's progress note dated 09/03/25 revealed the resident was hospitalized for sepsis due to a urinary tract infection. The note was absent of family notification. Review of Resident #22's RT progress note dated 09/07/25 revealed the resident failed to participate with the respiratory care. A small amount of secretions were removed from the tracheostomy and a nebulizer treatment was given. The resident's SpO2 was in the low 80 percentile on six liters of oxygen after the breathing treatment. The oxygen was increased to 10 liters and the residents SpO2 rose to 94%. Resident #22 was noted to have edema in her fingers and was was lethargic compared to her normal anxious energetic behaviors associated with the daily procedure. Emergency medical services were again</p> <p>(continued on next page)</p>		

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>called and the resident was transferred to the hospital emergency department for evaluation. Review of the medical record was void of Resident #22's emergency contacts being notified of the transfer. Review of the Quality Improvement Tool dated 09/03/25 and 09/07/25 related to the hospital transfers revealed no mention of the family of Resident #22 being notified of either of the transfers. Interview with Registered Nurse (RN) #112 revealed anytime a resident is transferred to the hospital a progress note should be placed in the electronic medical record and the family was immediately notified. Interview with the Director of Nursing on 01/22/26 at 1:55 P.M. verified Resident #22's medical record was absent of family notification of the resident's hospital transfer on both 09/03/25 and 09/07/25. Review of the facility policy titled Change in a Resident's Condition or Status dated 01/22/22 revealed unless otherwise instructed by the resident, a nurse will notify the resident's representative when it is necessary to transfer the resident to a hospital/treatment center. This deficiency represents non-compliance investigated under Complaint Number 2707152.</p>		