STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365517	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twilight Gardens Nursing and Rehabilitation	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents were included in care plan conference meetings. This affected four (#24, #50, #9, #13) of four residents reviewed for care planning. The facility census was 77. 1.Review of the medical record for Resident #24 revealed an admission date of 02/04/26. Diagnoses included depressive disorder, anxiety, type two diabetes mellitus, and chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment. Further review of the MDS assessments revealed the resident discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the resident's assessments from 02/04/26 through 03/19/26 revealed no documentation the resident had a care plan conference and no documentation the resident was invited to attend a care plan conference. Interview on 03/18/26 at 1:26 P.M. with Resident #24 revealed she had not been invited to participate in care planning meetings. Interview on 03/18/26 at 4:44 P.M. with Social Service Designee (SSD) #215 revealed residents should have care conference meetings upon admission, quarterly, and as needed. SSD #215 revealed letters were sent to the residents and their representatives. SSD # 215 revealed care conferences were usually held within seven days of admission. Interview on 03/19/25 at 8:19 A.M. with SSD #215 verified Resident #24 had not had a care conference as it must not have been scheduled. SSD #215 revealed being behind with care planning conferences for the new resident admissions. 2. Review of the medical record for Resident #50 revealed an admission date of 02/24/26. Diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, dependence on renal dialysis, dependence on ventilator status, gastrostomy status, and urinary incontinence. Review of the MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the care plan dated 03/18/26 revealed the resident was admitted to the facility for long term care. Interventions included to invite the resident and family to care conferences to discuss status and care. (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's assessments from 02/24/26 through 03/19/26 revealed no documentation the resident had an admission care plan conference and no documentation the resident/resident representative was invited to attend a care plan conference. Interview on 03/19/25 at 8:19 A.M. with SSD #215 verified Resident #50 had not had a care conference since admission. SSD #215 revealed she was behind with care conferences for the newly admitted residents. 3. Review of the medical record for Resident #13 revealed an admission on [DATE]. Diagnoses included paranoid schizophrenia, generalized anxiety disorder, and major depressive disorder. Review of the quarterly MDS 01/23/26 revealed Resident #13 had intact cognition, and was dependent on care for toileting, bathing, and transferring. Review of the care plan dated 07/17/25 revealed Resident #13 was admitted to the facility for long term care. Interventions included inviting the resident and family to care conference to discuss status and care, and address issues and concerns as they arise. Review of the medical record for Resident #13 revealed a Multidisciplinary Care Conference on 09/02/25 that was not completed. Further review of the Multidisciplinary Care Conference revealed there were no further care conferences held till 11/11/25. Interview with the DON on 03/19/26 at 11:50 A.M. confirmed that on 09/02/25 there was no documentation for the care conference, and no further care conference was held until 11/11/25. 4. Review of the medical record for Resident #9 revealed an admission date on 02/02/24. Diagnoses included paranoid schizophrenia, exudative age-related macular degeneration to the right eye, anxiety, and major depressive disorder. Review of the quarterly MDS dated [DATE] revealed Resident #9 had intact cognition. Resident #9 was independent with ADLs. Review of the care plan dated 02/02/24 revealed Resident #9 was admitted to the facility for long term care. Interventions included addressing issues and concerns as they arise, inviting the resident and family to care conferences to discuss status and care. Review of the medical record for Resident #9 revealed a Multidisciplinary Care Conference on 06/17/25 that was not completed. Interview on 03/19/26 at 11:50 A.M. with DON confirmed the Multidisciplinary Care Conference on 06/17/25 was not completed and care conferences were to be held every 90 days. Review of the facility policy titled, Care Plans, Comprehensive Person Centered dated 10/10/22, revealed the comprehensive, person-centered care plan is developed within seven days of the completed of the MDS assessment, and no more than 21 days after admission. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to initiate a baseline care plan. This affected one (#24) of four residents reviewed for care planning. The facility census was 77. Review of the medical record for Resident #24 revealed an admission date of 02/04/26. Diagnoses included depressive disorder, anxiety, type two diabetes mellitus, and chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment. Review of the resident's assessments revealed no documentation a baseline care plan was initiated upon admission. Interview on 03/19/26 at 8:25 A.M. with the Director of Nursing (DON) verified Resident #24 had no baseline care plan in place within 48 hours of admission. Further interview with the DON revealed the baseline care plan task was listed on the resident's admission checklist for the clinical staff to complete.Review of the facility policy, Care Plans-Baseline, revised 03/2022, revealed a baseline plan of care to meet the resident's immediate health and safety needs would be developed for each resident within forty-eight hours of admission. The baseline care plan would be used until the staff could conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan.

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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 review of the medical record, observation, staff interview, and policy review, the facility failed to ensure personal protective equipment (PPE) was worn while providing care to a resident with physician orders for enhanced barrier precautions (EBP). This affected one (#50) of three residents reviewed for infection control. The facility census was 71. Review of the medical record for Resident #50 revealed an admission date of 02/24/26. Diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, dependence on renal dialysis, dependence on ventilator status, gastrostomy status, and urinary incontinence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for toileting and personal hygiene. The resident was always incontinent of bladder. Review of a physician order dated 02/26/26 revealed Resident #50 had an order for enhanced barrier precautions. Review of the care plan dated 03/18/26 revealed Resident #50 was on EBPs secondary to increased risk for potential infection related to tracheostomy, gastrostomy, and wounds. Interventions included for staff to follow enhanced barrier precautions, hand hygiene before and after delivery of care, observe residents for signs and symptoms of infection, and educated resident and caregiver regarding infection prevention. Observation on 03/19/26 at 9:27 A.M. revealed Certified Nursing Assistant (CNA) #508 was providing care for Resident #50. CNA #508 was wearing gloves and was not wearing a gown. Further observation revealed the resident had a sign posted on the door indicating the resident was on enhanced barrier precautions and for staff to wear a gown and gloves during high contact resident care including hygiene and incontinence brief changes. Continued observations revealed PPE was available in an organizer bag hanging on the door. Interview on 03/19/26 at 9:29 A.M., CNA #508 verified he was providing incontinence care for Resident #50. CNA #508 verified the resident was on EBP and he was not wearing a gown while providing resident care. CNA #508 stated he forgot.Interview on 03/19/26 at 10:31 A.M., Infection Preventionist (IP) #250 revealed Resident #50 was on EBP and staff should be wearing a gown and glove during care. IP #250 revealed CNA #508 only worked on Unit One. Review of the facility policy Enhanced Barrier Precautions, dated 08/2022, revealed enhanced barrier precautions were utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. EBPs should be used for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Staff should wear gown and gloves during high contact resident care activities when contact precautions do not otherwise apply. High contact resident care activities require the use of gown and gloves for EBPs include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care.