

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Northwood Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Villa Road Springfield, OH 45503	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, the facility failed to ensure timely incontinence care was provided. This affected one (#72) of three residents reviewed for incontinence. The census was 76. Findings include: Medical record review for Resident #72 revealed an admission date of 07/27/21. Medical diagnoses included disorganized schizophrenia, heart failure, Alzheimer's disease, and cerebrovascular accident. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was severely cognitively impaired. Her functional status was set up or clean-up assistance with eating, dependent for toileting and transfers. She was substantial/maximal assistance for bed mobility. She was frequently incontinent for bladder and always incontinent for bowel. Observation of incontinence care for Resident #72 on 11/19/25 at 6:16 A.M. with Certified Nursing Assistant (CNA) #56 revealed the resident's brief was saturated and had leaked a small amount onto the incontinence pad she was lying on. The odor was pungent. Interview with the CNA #56 on 11/19/25 at 6:30 A.M. verified the brief was saturated and leaked onto the pad under the resident. She said she changed the resident at 2:15 A.M. and didn't know why she would be so wet. She confirmed the resident should be changed every two hours. This deficiency represents non-compliance discovered under Complaint Number 2642540.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview and policy review, the facility failed to ensure they were free from significant medication errors when the nurse failed to administer medications according to the physician orders. This affected six (#39, #05, #49, #10, #40, #75) of seven residents reviewed for late medications. The census was 76. Findings include: 1. Medical record review for Resident #75 revealed an admission date of 09/05/25. Medical diagnoses included acidosis, coronary artery disease, heart failure, and renal insufficiency. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #75 was cognitively intact. Review of the Medication Administration Audit Report dated 11/18/25 revealed the following medications were prescribed at 9:00 P.M., Pregabalin (anticonvulsant medication) capsule 25 milligrams (mg) to give one capsule two times a day, Atorvastatin (a cholesterol medication) Calcium Oral Tablet 40 mg to give one tablet at bedtime, Budesonide-Formoterol Fumarate (an asthma medication) Inhalation Aerosol 160-4.5 micrograms (mcg) to give two puffs a day, Trazadone (antidepressant medication) 150 mg to give one tablet, Lorazepam (a benzodiazepine medication) 0.5 mg. to give one tablet by mouth two times a day, Bupropion (antidepressant medication) 75 mg to give one tablet by mouth twice a day, Metformin (a medication to control blood sugar levels) 1000 mg to give twice a day. The above medication were given at 10:29 P.M. Interview with Resident #75 on 11/19/25 at 11:03 A.M. revealed her medications were late last night, 11/18/25, and would prefer them to be given on time. 2. Medical record review for Resident #48 revealed an admission date of 07/12/25. Medical diagnoses included chronic obstructive pulmonary disease, heart failure, and diabetes. Review of the admission MDS dated [DATE] revealed Resident #48 was cognitively intact. Review of the Medication Administration Audit Report dated 11/18/25 revealed the following medications were prescribed at 9:00 P.M. Atorvastatin 20 mg to give one and was given at 11:20 P.M. Divalproex (anticonvulsant medication) extended release give one tablet was given at 11:25 P.M. Lantus (insulin medication) give 30 units was given at 12:02 A.M. Haldol (antipsychotic medication) 10 mg give one two times a day and was given at 11:25 P.M. Gabapentin (anticonvulsant medication) 300 mg give three times a day was given at 11:25 P.M. Buspirone (antianxiety medication) 15 mg give three times a day was given at 11:20 P.M. Melatonin (a supplement) three mg give two tablets was given at 11:26 P.M. Interview with Resident #48 on 11/20/25 at 11:28 A.M. revealed she would like to get her medications around 9:00 P.M., but lately it has been more like 11:30 P.M. to 12:00 A.M. and she didn't like that. 3. Medical record review for Resident #10 revealed an admission date of 04/02/25. Medical diagnoses included dementia, heart failure, hypertension, and psychotic disorder. Review of the quarterly MDS dated [DATE] revealed Resident #10 was cognitively intact. Review of the Medication Administration Audit Report dated 11/18/25 revealed the following medications were prescribed at 9:00 P.M., Gabapentin 100 mg give one two times a day and Melatonin three mg give two tablets were given at 11:25 P.M. Interview with Resident #10 on 11/18/25 at 11:06 A.M. revealed at times his medications were late and he would like them on time. 4. Medical record review for Resident #49 revealed an admission date of 08/08/24. Medical diagnoses included acute respiratory failure with hypoxia, diabetes, bipolar disease and psychotic disorder. Review of the quarterly MDS dated [DATE] revealed Resident #49 was cognitively intact. Review of Medication Administration Audit Report dated 11/18/25 for medications prescribed for 9:00 P.M. revealed Depakote 500 mg give once a day was given at 11:20 P.M. Lantus give 30 units subcutaneously was given at 12:02 A.M. Haldol (antipsychotic medication) give one tablet twice a day was given at 11:25 P.M. 5. Medical record for Resident #05 revealed an admission date of 03/07/25. Review of diagnoses included spondylolisthesis lumbar region, cancer, renal insufficiency and neurogenic bladder. Review of the quarterly MDS dated [DATE] revealed Resident #5 was moderately cognitively impaired. Review of the Medication Administration Audit Report dated 11/18/25 revealed the following medications were prescribed for 9:00 P.M. , Pregabalin 75 mg twice a day, Metoprolol (blood pressure medication) 25 mg two times a day and Hydroxyzine (antihistamine medication) 10 mg one twice a day were given at 12:06 A.M. on 11/19/25. 6. Medical record review for Resident #39 revealed an admission date of 02/11/20. Medical diagnoses included dementia, peripheral vascular disease, and multiple sclerosis. Review of the quarterly MDS dated [DATE] revealed Resident #39 was severely cognitively impaired. Review of Medication Administration Audit Report dated 11/18/25 revealed the following medications prescribed for 9:00 P.M. Seroquel (antipsychotic medication) 150 mg two times a day, Melatonin 5 mg one tablet, Mirtazapine (antidepressant medication) 7.5</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interview, and policy review, the facility failed to ensure residents with enhanced barrier precautions (EBP) had clear signage or instruction indicating required personal protective equipment (PPE) and care activities that require what PPE. Additionally, the facility failed to ensure staff have awareness of the EBP policy. This affected 11 (#02, #05, #06, #10, #12, #19, #34, #36, #56, #68 and #73) of 11 residents reviewed for EBP. Additionally, the facility failed to clean and disinfect durable medical equipment (DME) between residents. This affected two residents (#14 and #78) of three reviewed. The facility also failed to ensure gloves were changed in between residents and hands were washed in-between resident care and after resident care. This affected one (#72) of three resident reviewed for incontinence care. The facility census was 76. Findings include:Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure residents with enhanced barrier precautions (EBP) had clear signage or instruction indicating required personal protective equipment (PPE) and care activities that require what PPE. Additionally, the facility failed to ensure staff have awareness of the EBP policy. This affected 11 (#02, #05, #06, #10, #12, #19, #34, #36, #56, #68 and #73) of 11 residents reviewed for EBP. Additionally, the facility failed to clean and disinfect durable medical equipment (DME) between residents. This affected two residents (#14 and #78) of three reviewed. The facility also failed to ensure gloves were changed between residents and hands were washed in-between resident care and after resident care. This affected one (#72) of three residents reviewed for incontinence care. The facility census was 76. Findings include:</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, chronic obstructive pulmonary disorder, and paranoid schizophrenia. Review of the care plan dated 04/11/24 revealed Resident #19 required enhanced barrier precautions due to suprapubic catheter. Interventions included educating staff on enhanced barrier precautions and enhanced barrier precautions will be maintained by staff per policy. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #19 was cognitively intact, had no behaviors, uses a walker for mobility, independent with eating, substantial assistance with toileting, and bathing. Review of Resident #19 physician orders revealed no orders for EBP. 2. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE]. Diagnoses included anemia, aneurysm of the ascending aorta, and depression. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 had moderately impaired cognition, had behaviors, independent with mobility, set up for eating, and supervision with toileting and bathing. Review of the care plan dated 10/12/25 revealed Resident #56 had no EBP documented in the care plan. Review of the medical record revealed Resident #56 did not have an order for EBP. 3. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE]. Diagnoses included gastroesophageal disease, generalized anxiety disorder, and bipolar disorder. Review of the care plan dated 08/18/25 revealed Resident #68 had enhanced barrier precautions due to complex wound/wound care with interventions including EBP will be maintained per policy. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 was cognitively intact, had no behaviors, used wheelchair for mobility, and set up for eating and bathing. Review of the medical record revealed Resident #68 did not have an order for EBP. 4. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE]. Diagnoses included paraplegia, generalized anxiety disorder, and anxiety disorder. Review of the care plan dated 01/10/25 revealed Resident #73 requiring enhanced barrier precautions due to complex wound condition with interventions including educating staff on EBP and EBP will be maintained by staff per policy. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #73 was cognitively intact, had no behaviors, uses wheelchair for mobility, and was independent with eating and bathing. Review of the medical record revealed Resident #73 did not have an order for EBP. Observations and interview with the Director of Nursing (DON) on 11/18/25 from 12:25 P.M. to 12:45 P.M. revealed residents (#02, #05, #06, #10, #12, #19, #34, #36, #56, #68 and #73) rooms had a magnetic square with EP written on the magnetic square and no other information was available on the status which was verified by the DON. Interview on 11/18/25 at 11:54 A.M. with Licensed Practical Nurse (LPN) #57 revealed residents have EBP when they have open wounds and catheters. The LPN #57 revealed they put on all PPE when providing any care to residents. Interview on 11/18/25 at 12:20 P.M. with Certified Nursing Assistant (CNA) #100 revealed they were aware of what to put on for residents in EBP because CNA #100 knows all the residents. CNA #100 stated if there was a new resident that went into EBP would ask the nurse or the DON what to put on for any resident care. Interview on 11/18/25 at 10:48 A.M. with Registered Nurse (RN) #101 revealed not aware of what the EP on the doors stand for and what to do if care must be provided in those resident rooms labeled with EP. Interview on 11/18/25 at 12:09 P.M. with CNA #102 revealed unsure of what PPE to wear when providing care to residents with EP on the door and would have to ask a nurse. Interview on 11/18/25 at 12:25 P.M. to 12:45 P.M. with the DON revealed staff were educated on putting full PPE on for any high contact care for residents with EBP. The DON revealed the staff are trained on EBP monthly at staff meetings and when newly hired. The DON also stated if a staff does not know what to put on or to do for EBP they can ask a nurse in the building. The DON confirmed the PPE cart is placed inside the room or outside the room depending on resident preference and there is no distinction at the door for which resident in the room is in EBP. The DON confirmed there is no additional signage at the door for a resident in EBP, staff would look in the resident chart if they needed to know. The DON stated there was no order for EBP, it was only documented in the resident care plan. Interview on 11/19/25 at 7:17 A.M. with CNA #82 revealed if the resident is in EBP there is usually a letter outside of the resident rooms to let the staff know what to wear for resident care. Interview and observation on 11/19/25 from 7:55 A.M. to 8:00 A.M. with Nurse Practitioner (NP) #110 revealed NP#110 walked into resident #73's room, which was labeled to be EBP, to do a dressing change. Observed the NP #110 walk out of the resident #73's room with no gown, door was open the entire time, the NP #110</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. Medical record review for Resident #55 revealed an admission date of 11/17/24. Medical diagnoses included after care for a fracture of the left femur.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #55 was severely cognitively impaired. Her functional status was substantial/maximal assistance for eating, toileting, bed mobility, and transfers. She was always incontinent of bowel and bladder.</p> <p>During an observation on 11/19/25 at 6:16 A.M. CNA #117 revealed she had on two pairs of gloves and had finished incontinence care for Resident #55. The aide placed the covers back over the resident and then went to Resident #72's side of the room. CNA #33 had prepared the water for incontinence care for Resident #72. CNA #117 wiped the face and neck of Resident #72 and removed her shirt and washed under her breasts and armpits. She continued with the same gloves and provided incontinent care for the resident and removed the first pair of gloves on her hands. CNA #117 continued to dress Resident #72. She emptied the basin of water and put things away in the room. Right before she was ready to walk out into the hallway the Director of Nursing (DON), who was observing the interaction reminded the aide to take off her gloves before leaving the room and had not washed her hands before leaving the room and walked down the hall to the shower room to dispose of the dirty items from Resident #72's room.</p> <p>Interview with CNA #117 on 11/19/25 at 6:40 A.M. confirmed she had not changed her gloves in between residents and had not washed her hands in between residents or before leaving the room. She stated that was not her normal practice and should have changed her gloves and washed her hands.</p> <p>Review of policy titled Handwashing and Hand Hygiene dated 08/01/19 revealed to use an alcohol-based hand rub containing at least 62% alcohol, an approved non-alcohol-based hand sanitizer or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:</p> <p>a. Before and after coming on duty.b. Before and after direct contact with residents.c. After contact with a resident's intact skin.d. After contact with blood or bodily fluids.e. After removing gloves.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2642540.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of the water temperature logs, and review of a plumbing invoice, the facility failed to ensure water temperatures were within normal limits. This affected one (#72) of three residents reviewed for water temperatures. The census was 76. Findings include: Medical record review for Resident #72 revealed an admission date of 07/27/21. Medical diagnoses included disorganized schizophrenia, heart failure, Alzheimer's disease, and cerebrovascular accident. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was severely cognitively impaired. Her functional status was set up or clean-up assistance with eating, dependent for toileting and transfers. She was substantial/maximal assistance for bed mobility. She was frequently incontinent of bladder and always incontinent for bowel. Review of an invoice from a plumbing company dated 11/11/25 revealed the mixing valve from the hot water had to be replaced. Review of the temperatures for the water for the 200-hall dated 11/18/25 revealed they were within normal limits. Review of the invoice dated 11/19/25 after the incontinence care revealed there was a new mixing valve replaced due malfunction of the one placed on 11/11/25. During an observation of incontinence care on 11/19/25 at 6:16 A.M. with Certified Nursing Assistant (CNA) #117 and CNA #33 revealed CNA #33 went into the bathroom to prepare water for the care but had to leave the room to go to another room to get water that was warm and came back into the room. During the care resident #72 was uncomfortable with the water temperature and she would pull away from the washcloth when the aides tried to wash under her arms, face and peri-care. The aides acknowledged the resident was cold from the cold water they were washing her with and continued with the care. Observation of the water temperature on 11/19/25 at 6:30 A.M. revealed the water temperature was taken by the Director of Nursing (DON) and the thermometer read 93.7 degrees Fahrenheit. The DON confirmed the water was too cold. Interview with CNA #33 on 11/19/25 at 6:35 A.M. revealed the water temperature had been a problem lately and the facility had someone out to fix it and it worked for a while and now it was not working anymore. She stated she tried to get warmer water by leaving the room, but it was only lukewarm. There wasn't a policy to review and the Administrator said they follow the regulatory guidelines.</p>		