

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Norwood Towers Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Sherman Avenue 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff and resident interviews, and policy review, the facility failed to accommodate the residents who wanted showers versus bed baths. This affected one (Resident #40) of three residents reviewed for bathing. The facility census was 108. Review of the medical record for Resident #40 revealed an admission date of 08/26/25. Diagnoses included chronic kidney disease, peripheral vascular disease (PVD), and mood disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. This resident was assessed to require substantial assistance with toileting and dressing, bathing and transfers. Review of the documented showers for January and February 2026 for Resident #40 revealed the following: a) On 01/05/26, no shower was given. b) On 01/06/26, a bed bath was given. c) On 01/08/26, not applicable was documented. d) On 01/12/26, a bed bath was given. e) On 01/26/26, no shower was given. f) On 01/27/26, a bed bath was given. g) On 01/29/26, no documentation. h) On 02/02/26, not applicable was documented. i) On 02/09/26, not applicable was documented. Interview on 02/10/26 at 2:45 P.M. Resident #40 stated he was not getting his showers as required. Interview on 02/11/26 at 9:31 A.M. Director of Nursing (DON) stated Resident #47 preferred a bed bath versus a shower. Subsequent interview on 02/11/26 at 10:03 A.M. Resident #40 stated he preferred a shower over a bed bath, but staff were not giving him the option. Review of the facility policy titled, Resident Rights, dated August 2009 revealed employees shall treat all residents with kindness, respect, and dignity. Residents were entitled to exercise their rights and privileges to the fullest extent possible.		

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to ensure physicians/providers were notified of a significant change in resident status and failed to notify the physicians/providers when a resident was moved to the secured Memory Care Unit. This affected one (Resident #47) of three residents reviewed for significant changes. The facility census was 108. Review of the medical record for Resident #47 revealed an admission date of 01/13/22. Diagnoses included chronic obstructive pulmonary disease (COPD), type I diabetes mellitus (DM I), and paranoid schizophrenia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and setup with bathing. Review of the progress note dated 01/24/26 at 6:45 P.M. revealed Resident #47 was lying in bed, and her coat was at the foot of the bed smoldering due to a cigarette butt that she previously smoked. Resident #47 was evacuated from her room to a safe place as her coat was extinguished. Resident #47 was educated on the importance of not bringing previously lit cigarettes into the building. Review of the late entry progress note dated 01/24/26 at 11:19 P.M. revealed Resident #47 was moved to second floor secured unit due to Resident #47 now being a supervised smoker at all times. Interview on 01/28/26 at 3:14 P.M. Medical Director (MD) #100 stated she was not informed of the smoking incident involving Resident #47 until 01/27/26. MD #100 also stated she was not informed of the resident being moved to the secured Memory Care Unit. Interview on 01/28/26 at 4:56 P.M. Nurse Practitioner (NP) #90 stated she was not informed of the smoking incident involving Resident #47 until 01/27/26 and also stated she was not informed of the resident being moved to the secured Memory Care Unit. Interview on 01/29/26 at 10:09 A.M. Psychiatric NP #80 stated he was not informed of the smoking incident involving Resident #47 until 01/29/26. PNP #80 stated he was asked today within the last 20 minutes via phone to provide an order for the resident to be housed in the secured memory care unit. Interview on 01/29/26 at 10:35 A.M. the DON stated Resident #47 was moved to the secured Memory Care Unit on the second floor because she was now a supervised smoker and the Memory Care Unit was the only place the facility had supervised smokers. The DON wouldn't answer if the resident was appropriate for placement on the secured unit but stated Resident #47 was agreeable to be moved to the secured memory care unit. Review of the facility policy titled, Change in a Resident's Condition or Status, revised May 2017 revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and facility policy, the facility failed to ensure residents were free from abuse. This affected two Residents (#65 and #111) of four residents reviewed for abuse. The facility census was 108. 1) Review of the medical record for Resident #111 revealed an admission date of 10/10/25 with a discharge date of 02/03/26. Diagnoses included malignant neoplasm of brain, hypertension, and metabolic encephalopathy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #111 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. Review of the progress note dated 12/30/25 at 8:00 A.M. revealed Resident #111 had facial trauma per the staff from a physical disturbance between him and Resident #65, and then they were separated immediately. Resident #111 was assessed with redness on his face and nose, and small hematoma on the right side of his head. Resident #111 was nonverbal but appeared comfortable. There were no other obvious injuries or deformities noted. X-rays of the skull, facial bones, and cervical spine were ordered. The staff will continue to monitor and notify provider of any worsening conditions. Review of the late entry progress note for 12/30/25 at 7:52 P.M. revealed Resident #111 received physical aggression from Resident #65 resulting in injuries. The staff intervened and separated both residents. Both residents were placed on a one-to-one. Resident #111 was assessed from head to toe, with injuries noted to the facial area. The responsible parties were notified and X-ray was ordered. Review of the late entry progress note for 12/31/25 at 9:05 A.M. revealed Resident #111 appeared to have been injured from an unwitnessed incident involving Resident #65. A full body assessment was done, and injuries were limited to facial bruising and hematoma on his forehead. Resident #111 was provided first-aid and care. An x-ray was obtained, which was unremarkable. Resident #111 displayed no signs of distress or pain. Review of the comprehensive skin evaluation dated 12/30/25 at 6:41 P.M. revealed Resident #111 had facial bruising, swelling, bloody nose, and a bump/knot on his head. 2) Review of the medical record for Resident #65 revealed an admission date of 01/23/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, mood disorder, and peripheral vascular disease (PVD). Review of the Annual MDS assessment dated [DATE] revealed Resident #65 could not complete a BIMS because he was rarely/never understood. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and setup with bathing. Review of the progress note dated 12/30/25 at 7:00 P.M. revealed at time of incident, Certified Nursing Assistant (CNA) #12 came to the nurse's station and stated Resident #65 struck Resident #111 in the face. The staff intervened and separated both residents and placed Resident #65 on one-to-one supervision. Nurse practitioner (NP) #90 gave orders to send Resident #65 to the hospital to be evaluated. A skin assessment was completed with no injuries noted. Review of the late entry progress note for 12/31/25 at 9:0		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bleeding from. Resident #65 was sent out later in the evening to be evaluated. Interview on 02/10/26 at 12:35 P.M. CNA #12 stated she was walking down the hallway when she saw Resident #65 standing in the doorway of Resident #111's room and Resident #65 started swinging his arms. CNA #12 reported Resident #111's face was red and bleeding from his nose. CNA #12 asked Resident #65 why he did that, and Resident #65 said he expletive him up. CNA #12 walked Resident #111 to the nurse's station to be evaluated. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, revised March 2018 revealed the physician, and staff would help identify risk factors for abuse within the facility. The staff, with the physician's input, would investigate alleged abuse and neglect to clarify what happened and identify possible causes. The facility management and staff would institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, would address situations of suspected abuse or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. This deficiency represents non-compliance investigated under Complaint Number 2729914.		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff and resident interviews, and policy review, the facility failed to ensure residents were free from involuntary seclusion. This affected one (Resident #47) of three resident reviewed for smoking. The facility census was 108. Review of the medical record for Resident #47 revealed an admission date of 01/13/22. Diagnoses included chronic obstructive pulmonary disease (COPD), type I diabetes mellitus (DM I), and paranoid schizophrenia. Review of the smoking observation assessment dated [DATE] revealed Resident #47 was an independent smoker with no cognitive impairment. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and setup with bathing. Review of the progress note dated 01/24/26 at 6:45 P.M. revealed Resident #47 was lying in bed, and her coat was at the foot of the bed smoldering due to a cigarette butt that she previously smoked. Resident #47 was evacuated from her room to a safe place as her coat was extinguished. Resident #47 was educated on the importance of not bringing previously lit cigarettes into the building. Review of the late entry progress note dated 01/24/26 at 11:19 P.M. revealed Resident #47 was moved to second floor secured Memory Care Unit due to Resident #47 now being a supervised smoker at all times. Review of the smoking observations assessment dated [DATE] revealed Resident #47 was a supervised smoker who was not cognitively impaired. Interview on 01/29/26 at 9:48 A.M. Director of Nursing (DON) stated all residents on the first and third floors were independent smokers. The DON reported all residents on the secured Memory Care Unit were supervised smokers. The DON stated the Psychiatric Nurse Practitioner (PNP) #80 gave an order on 01/24/26 for Resident #47 to be placed on secure unit. Interview on 01/29/26 at 10:09 A.M. Psychiatric NP #80 stated he was not informed of the smoking incident involving Resident #47 until 01/29/26. PNP #80 stated he was asked today within the last 20 minutes via phone to provide an order for the resident to be housed in the secured Memory Care Unit. Interview on 01/29/26 at 10:35 A.M. the DON stated Resident #47 was moved to the secured Memory Care Unit on the second floor because she was now a supervised smoker and the Memory Care Unit was the only place the facility had supervised smokers. The DON wouldn't answer if the resident was appropriate for the unit but stated Resident #47 was agreeable to be moved to the secured unit. Interview on 01/29/26 at 1:26 P.M. Resident #47 stated she was informed she was being moved to the secured Memory Care Unit but was not agreeable. Review of the physician orders for Resident #47 dated 01/29/26 revealed an order for Resident #47 to be housed in the secure Memory Care Unit. Observations throughout the survey from 01/28/26 through 02/11/26 revealed Resident #47 was housed in the secured Memory Care Unit. Review of the facility policy titled, Smoking Policy of [NAME] Towers Post-Acute dated 11/02/25 revealed supervised smokers had all smoking articles including lights, cigarettes, and electronic devices were		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interviews, and policy review, the facility failed to implement their abuse policy when an allegation of abuse was reported. This affected two Residents (#65 and #111) of the four residents reviewed for abuse. The facility census was 108 1) Review of the medical record for Resident #111 revealed an admission date of 10/10/25 with a discharge date of 02/03/26. Diagnoses included malignant neoplasm of brain, hypertension, and metabolic encephalopathy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #111 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require partial assistance with eating, dependent on toileting, bathing, and dressing, and setup for transfers. Review of the progress note dated 12/30/25 at 8:00 A.M. revealed Resident #111 had facial trauma per the staff from a physical disturbance between him and Resident #65, and then they were separated immediately. Resident #111 was assessed with redness on his face and nose, and small hematoma on the right side of his head. Resident #111 was nonverbal but appeared comfortable. There were no other obvious injuries or deformities noted. X-rays of the skull, facial bones, and cervical spine were ordered. The staff will continue to monitor and notify provider of any worsening conditions. Review of the late entry progress note for dated 12/30/25 at 7:52 P.M. revealed Resident #111 received physical aggression from Resident #65 resulting in injuries. The staff intervened and separated both residents. Both residents were placed on a one-to-one observation. Resident #111 was assessed from head to toe, with injuries noted to the facial area. The responsible parties were notified and X-ray was ordered. Review of the late entry progress note for 12/31/25 at 9:05 A.M. revealed Resident #111 appeared to have been injured from an unwitnessed incident involving Resident #65. A full body assessment was done, and injuries were limited to facial bruising and hematoma on his forehead. Resident #111 was provided first-aid and care. An x-ray was obtained, which was unremarkable. Resident #111 displayed no signs of distress or pain. Review of the comprehensive skin evaluation dated 12/30/25 at 6:41 P.M. revealed Resident #111 had facial bruising, swelling, bloody nose, and a bump/knot on his head. 2) Review of the medical record for Resident #65 revealed an admission date of 01/23/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, mood disorder, and peripheral vascular disease (PVD). Review of the Annual MDS assessment dated [DATE] revealed Resident #65 could not complete a BIMS because he was rarely/never understood. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and setup with bathing. Review of the progress note dated 12/30/25 at 7:00 P.M. revealed at time of incident, Certified Nursing Assistant (CNA) #12 came to the nurse's station and stated Resident #65 struck Resident #111 in the face. The staff intervened and separated both residents and placed Resident #65 on one-to-one supervision. Nurse Practitioner (NP) #90 gave orders to send Resident #65 to the hospital to be		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/10/26 at 10:28 A.M. Licensed Practical Nurse (LPN) #23 stated CNA #12 reported the incident with Resident #65 and Resident #111 and intervened. LPN #23 reported Resident #111 had redness to his face and a hematoma to the right side of his forehead. LPN #23 stated both residents were assessed and placed on one-to-one supervision. Interview on 02/10/26 at 12:05 P.M. LPN #24 stated CNA #12 came into the nurse's station and reported Resident #65 struck Resident #111. Both residents were assessed and placed on a one-to-one supervision. Resident #111 had bruising/redness to the right side of his face and blood but could not recall where he was bleeding from. Resident #65 was sent out later in the evening to be evaluated. Interview on 02/10/26 at 12:35 P.M. CNA #12 stated she was walking down the hallway when she saw Resident #65 standing in the doorway of Resident #111's room and Resident #65 started swinging his arms. CNA #12 reported Resident #111's face was red and bleeding from his nose. CNA #12 asked Resident #65 why he did that, and Resident #65 said he expletive him up. CNA #12 walked Resident #111 to the nurse's station to be evaluated. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, revised March 2018 revealed the physician, and staff would help identify risk factors for abuse within the facility. The staff, with the physician's input, would investigate alleged abuse and neglect to clarify what happened and identify possible causes. The facility management and staff would institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, would address situations of suspected abuse or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. This deficiency represents non-compliance investigated under Complaint Number 2729914.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interviews, and policy review, the facility failed to report alleged abuse to the state agency. This affected two Residents (#65 and #111) of four residents reviewed for abuse. The facility census was 108. 1) Review of the medical record for Resident #111 revealed an admission date of 10/10/25 with a discharge date of 02/03/26. Diagnoses included malignant neoplasm of brain, hypertension, and metabolic encephalopathy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #111 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require partial assistance with eating, dependent on toileting, bathing, and dressing, and setup for transfers. Review of the progress note dated 12/30/25 at 8:00 A.M. revealed Resident #111 had facial trauma per the staff from a physical disturbance between him and Resident #65, and then they were separated immediately. Resident #111 was assessed with redness on his face and nose, and small hematoma on the right side of his head. Resident #111 was nonverbal but appeared comfortable. There were no other obvious injuries or deformities noted. X-rays of the skull, facial bones, and cervical spine were ordered. The staff will continue to monitor and notify provider of any worsening conditions. Review of the late entry progress note for dated 12/30/25 at 7:52 P.M. revealed Resident #111 received physical aggression from Resident #65 resulting in injuries. The staff intervened and separated both residents. Both residents were placed on a one-to-one observation. Resident #111 was assessed from head to toe, with injuries noted to the facial area. The responsible parties were notified and X-ray was ordered. Review of the late entry progress note for 12/31/25 at 9:05 A.M. revealed Resident #111 appeared to have been injured from an unwitnessed incident involving Resident #65. A full body assessment was done, and injuries were limited to facial bruising and hematoma on his forehead. Resident #111 was provided first-aid and care. An x-ray was obtained, which was unremarkable. Resident #111 displayed no signs of distress or pain. Review of the comprehensive skin evaluation dated 12/30/25 at 6:41 P.M. revealed Resident #111 had facial bruising, swelling, bloody nose, and a bump/knot on his head. 2) Review of the medical record for Resident #65 revealed an admission date of 01/23/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, mood disorder, and peripheral vascular disease (PVD). Review of the Annual MDS assessment dated [DATE] revealed Resident #65 could not complete a BIMS because he was rarely/never understood. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and setup with bathing. Review of the progress note dated 12/30/25 at 7:00 P.M. revealed at time of incident, Certified Nursing Assistant (CNA) #12 came to the nurse's station and stated Resident #65 struck Resident #111 in the face. The staff intervened and separated both residents and placed Resident #65 on one-to-one supervision. Nurse Practitioner (NP) #90 gave orders to send		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to report the incident between Residents #111 and #65 to the stage agency. Interview on 02/10/26 at 10:28 A.M. Licensed Practical Nurse (LPN) #23 stated CNA #12 reported the incident with Resident #65 and Resident #111 and intervened. LPN #23 reported Resident #111 had redness to his face and a hematoma to the right side of his forehead. LPN #23 stated both residents were assessed and placed on one-to-one supervision. Interview on 02/10/26 at 12:05 P.M. LPN #24 stated CNA #12 came into the nurse's station and reported Resident #65 struck Resident #111. Both residents were assessed and placed on a one-to-one supervision. Resident #111 had bruising/redness to the right side of his face and blood but could not recall where he was bleeding from. Resident #65 was sent out later in the evening to be evaluated. Interview on 02/10/26 at 12:35 P.M. CNA #12 stated she was walking down the hallway when she saw Resident #65 standing in the doorway of Resident #111's room and Resident #65 started swinging his arms. CNA #12 reported Resident #111's face was red and bleeding from his nose. CNA #12 asked Resident #65 why he did that, and Resident #65 said he expletive him up. CNA #12 walked Resident #111 to the nurse's station to be evaluated. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, revised March 2018 revealed the physician, and staff would help identify risk factors for abuse within the facility. The staff, with the physician's input, would investigate alleged abuse and neglect to clarify what happened and identify possible causes. The facility management and staff would institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, would address situations of suspected abuse or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. This deficiency represents non-compliance investigated under Complaint Number 2729914.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interviews, and facility policy, the facility failed to thoroughly investigate alleged abuse. This affected two (#65 and #111) of four residents reviewed for abuse. The facility census was 108. 1) Review of the medical record for Resident #111 revealed an admission date of 10/10/25 with a discharge date of 02/03/26. Diagnoses included malignant neoplasm of brain, hypertension, and metabolic encephalopathy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #111 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. This resident was assessed to require partial assistance with eating, dependent on toileting, bathing, and dressing, and setup for transfers. Review of the progress note dated 12/30/25 at 8:00 A.M. revealed Resident #111 had facial trauma per the staff from a physical disturbance between him and Resident #65, and then they were separated immediately. Resident #111 was assessed with redness on his face and nose, and small hematoma on the right side of his head. Resident #111 was nonverbal but appeared comfortable. There were no other obvious injuries or deformities noted. X-rays of the skull, facial bones, and cervical spine were ordered. The staff will continue to monitor and notify provider of any worsening conditions. Review of the late entry progress note for dated 12/30/25 at 7:52 P.M. revealed Resident #111 received physical aggression from Resident #65 resulting in injuries. The staff intervened and separated both residents. Both residents were placed on a one-to-one observation. Resident #111 was assessed from head to toe, with injuries noted to the facial area. The responsible parties were notified and X-ray was ordered. Review of the late entry progress note for 12/31/25 at 9:05 A.M. revealed Resident #111 appeared to have been injured from an unwitnessed incident involving Resident #65. A full body assessment was done, and injuries were limited to facial bruising and hematoma on his forehead. Resident #111 was provided first-aid and care. An x-ray was obtained, which was unremarkable. Resident #111 displayed no signs of distress or pain. Review of the comprehensive skin evaluation dated 12/30/25 at 6:41 P.M. revealed Resident #111 had facial bruising, swelling, bloody nose, and a bump/knot on his head. 2) Review of the medical record for Resident #65 revealed an admission date of 01/23/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, mood disorder, and peripheral vascular disease (PVD). Review of the Annual MDS assessment dated [DATE] revealed Resident #65 could not complete a BIMS because he was rarely/never understood. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and setup with bathing. Review of the progress note dated 12/30/25 at 7:00 P.M. revealed at time of incident, Certified Nursing Assistant (CNA) #12 came to the nurse's station and stated Resident #65 struck Resident #111 in the face. The staff intervened and separated both residents and placed Resident #65 on one-to-one supervision. Nurse Practitioner (NP) #90 gave orders to send Resident #65 to the hospital to be evaluated. A skin assessment was completed with no injuries noted. Review of the late		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Norwood Towers Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Sherman Avenue 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between Resident #111 and #65. Interview on 02/10/26 at 10:28 A.M. Licensed Practical Nurse (LPN) #23 stated CNA #12 reported the incident with Resident #65 and Resident #111 and intervened. LPN #23 reported Resident #111 had redness to his face and a hematoma to the right side of his forehead. LPN #23 stated both residents were assessed and placed on one-to-one supervision. Interview on 02/10/26 at 12:05 P.M. LPN #24 stated CNA #12 came into the nurse's station and reported Resident #65 struck Resident #111. Both residents were assessed and placed on a one-to-one supervision. Resident #111 had bruising/redness to the right side of his face and blood but could not recall where he was bleeding from. Resident #65 was sent out later in the evening to be evaluated. Interview on 02/10/26 at 12:35 P.M. CNA #12 stated she was walking down the hallway when she saw Resident #65 standing in the doorway of Resident #111's room and Resident #65 started swinging his arms. CNA #12 reported Resident #111's face was red and bleeding from his nose. CNA #12 asked Resident #65 why he did that, and Resident #65 said he expletive him up. CNA #12 walked Resident #111 to the nurse's station to be evaluated. Review of the facility policy titled, Abuse and Neglect - Clinical Protocol, revised March 2018 revealed the physician, and staff would help identify risk factors for abuse within the facility. The staff, with the physician's input, would investigate alleged abuse and neglect to clarify what happened and identify possible causes. The facility management and staff would institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The management and staff, with physician support, would address situations of suspected abuse or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. This deficiency represents non-compliance investigated under Complaint Number 2729914.		