STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366238	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Towers Post-Acute	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were free of significant medication errors. This affected one (Resident #44) of three residents reviewed for medication administration. The facility census was 101 residents. Findings include: Review of the medical record for Resident #44 revealed an admission date of 11/24/15 with diagnoses including cerebral infarction, type two diabetes, and dementia. Review of the Minimum Data Set (MDS) assessment for Resident #44 dated 02/10/26 revealed the resident had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs).Review of a progress note for Resident #44 dated 02/18/26 per Nurse Practitioner (NP) #368 revealed she was notified that nursing staff had administered the wrong medications to the resident on 02/17/26. Resident #44 received Clozapine 200 milligrams (mg), Depakote 250 mg, Niacin 250 mg, and Haldol mg. Staff notified the on-call provider when the incident occurred, and the provider gave orders for labs and to check the resident's vital signs every four hours. Staff reported on 02/18/26 that Resident #44 was lethargic and hard to rouse, was drooling, had an elevated heart rate, and had three episodes of emesis. NP #368 contacted poison control, and staff sent Resident #44 to the emergency department for further evaluation upon the recommendation of poison control. Review of nurse progress note for Resident #44 dated 02/18/26 revealed staff administered the wrong medication to Resident #44 on 2/17/26. On the morning of 02/18/26 Resident #44 presented as lethargic and difficult to rouse and had three episodes of vomiting and drooling. Staff notified NP#368 who gave an order to send Resident #44 to the hospital. Review of the hospital discharge paperwork for Resident #44 dated 02/18/26 revealed the resident was admitted to the hospital on [DATE] due to unintentional ingestion of medications not prescribed. She had a computed tomography (CT) scan that showed no acute intracranial abnormality. Her mental status improved back to baseline after 24 hours.Interview on 02/24/26 at 4:15 P.M. with Medication Technician (MT #272) confirmed when she was completing medication administration on the evening of 02/17/26 she pulled the medication for a resident. MT #272 stated she became distracted by another resident and when she saw Resident #44 by the medication cart she administered the medication she had pulled. MT #272 reported she then realized she had administered the wrong medication to Resident #44 and immediately notified the nurse who reported the incident to the on-call provider. Interview on 02/24/26 at 3:00 P.M. with Resident #44 confirmed facility staff gave her the wrong medication and she was sent to the hospital afterwards. Interviews on 02/24/26 at 5:10 P.M. with the Administrator and the Director of Nursing (DON) confirmed MT #272 administered the wrong medication to Resident #44 on 02/17/26 and the resident had to go to the hospital for evaluation on 02/18/26 and returned with no new orders. Review of the facility policy titled Administrating Medication revised April 2019 revealed the individual administering the medication should verify the residents identity before giving them medication. The (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individual administering the medication should check the label three times to verify the right resident, the right medication, the right dosage, the right time and the right method before administering the medication. The deficiency was corrected on 02/23/26 after the facility implemented the following corrective actions:-On 02/17/26 staff assessed Resident #44 and notified the on-call provider of the medication error. Immediate action was taken on 02/17/26 to ensure the safety of the resident. Staff implemented the order to check the resident's vital signs every four hours and to monitor the resident. -On 02/17/26 the DON, two Assistant Directors of Nursing (ADONs), and Regional Clinical Consultant conducted a root cause analysis of the medication error and determined the root cause of the incident was staff was distracted. The facility developed a plan of action by 02/18/26. -On 02/17/26 the DON re-educated MT #272 and reviewed expectations related to resident identification and verification prior to medication delivery.-On 02/18/26 staff sent Resident #44 to the emergency room for evaluation related to the medication error on 02/17/26. The resident returned with no new orders. -On 02/18/26 the DON began re-education of all nurses and MTs on the five rights of medication administration with specific emphasis on maintaining focus during medication passes, avoiding distractions and completing resident identification verification prior to each administration. Education of all nurses and MTs was completed on 02/18/26. -Starting on 02/18/26 the DON or Designee began completion of medication administration competencies for all nurses and MTs. Competencies included direct observation of resident identification practices, demonstration of the five rights of medication administration, proper use of medication administration records and safe response to interruptions during medication passes. Any staff unable to successfully demonstrate the competencies would receive one-on-one re-education and re-evaluation prior to resuming independent medication administration duties. Five competencies had been completed by 02/23/26 with competencies to continue until after nurse and MT had successfully completed the competency. -Starting 02/18/26 the DON or designee began conducting random medication administration audits on a minimum of five residents for four weeks and as needed thereafter with findings reviews at Quality Assurance Performance Improvement (QAPI) meetings.This deficiency represents noncompliance investigated under Complaint Number 2747068.