STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366492	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwich Springs Health Campus	4680 Library Way Hilliard, OH 43026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident record, observations and staff interviews, the facility failed to ensure dignity for a resident. This affected one resident (Resident #58) of three residents reviewed for dignity. The facility census was 52 residents. Findings include: Resident #58 was admitted to the facility on [DATE] and had diagnoses that included cirrhosis and ascites, mood disorder, and alcohol induced major neurocognitive disorder. Review of Resident #58's Brief Interview for Mental Status (BIMS) score on 03/23/26 revealed that he had a score of eight indicative of moderately impaired cognitive status.An observation on 03/23/26 at 2:46 P.M. revealed that Resident #58 was able to be viewed from his open room door from the hallway. Resident #58 was dressed in a gown, sitting on a shower chair, with his buttocks exposed. An interview with Certified Resident Care Associate #413 and Registered Nurse #38 on 03/23/26 at 2:46 P.M. confirmed Resident #58's exposed buttocks were visible from the hallway. Certified Resident Care Associate #413 revealed she had heard a resident in an adjacent room yell, so she left Resident #58's room quickly to check on the resident in the room next door. Certified Resident Care Associate #413 revealed in her haste, she had forgotten to shut the door or pull the privacy curtain for Resident #58.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to provide oxygen therapy services per physician's order for Resident #52 and Resident #33, the facility also failed to ensure the nasal cannula was kept in sanitary condition for Resident #33. This affected two Residents (#52 and #33) of four reviewed for respiratory services. It had the potential to affect 10 residents the facility identified as using oxygen therapy in their plan of care. The facility census was 52.Findings include: 1.Resident #52 was admitted on [DATE] with diagnoses that included sepsis due to Methicillin resistant Staphylococcus aureus (MRSA) and pulmonary hypertension. Review of the Resident #52's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident used continuous oxygen therapy and was cognitively intact. Review of Resident #52's physician orders revealed an order written on 3/11/26 for oxygen to be administered at three liters (L)(per minute) per nasal cannula continuous. Observation on 03/25/26 at 8:53 A.M. revealed Resident #52 resting in bed and the gauge on the oxygen concentrator indicated the oxygen was being delivered at two L per minute. Concurrent interview with Registered Nurse (RN) #378 who was present for the observation confirmed the oxygen was being delivered at two L per minute. Further interview with RN #378 at 8:56 A.M. on 3/25/26 confirmed that the physician's order for delivery of oxygen was three L per minute. Review of the Clinical Standard Operating Procedure (SOP) titled Administration of Oxygen (reviewed 12/13/24) revealed staff are to verify the physician's order for administering oxygen. The SOP further directs staff to start the flow of oxygen at a rate of two to three Liters per minute, unless otherwise ordered. 2. Review of the medical record for Resident #33 revealed an admission date of 03/04/26. Diagnoses included paroxysmal atrial fibrillation, gastrointestinal hemorrhage, acute respiratory failure with hypoxia, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) 3.0 assessment for Resident #33, dated 03/10/26, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The assessment indicated the resident was receiving oxygen therapy. Review of physician orders for Resident #33 revealed an order dated 02/23/26 for oxygen at two liters per minute via nasal cannula continuously and an order dated 02/23/26 to change oxygen tubing monthly. Observation on 03/25/26 at 9:14 A.M. revealed the nasal cannula was hanging on the side of the bed and was not stored in a sanitary bag. The nasal prongs were observed pressed against the side of the hospital bed. During this observation, Certified Nursing Assistant (CNA) #364 was present and observed to placed the nasal cannula on the resident without replacing it. Concurrent interview with CNA #364 confirmed the nasal cannula should be stored in a sanitary bag when not in use. Observation on 03/25/26 at 9:28 A.M. with Registered Nurse (RN) #284 revealed the oxygen concentrator was set at two and a half liters per minute. Interview at that time with RN #284 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the oxygen flow rate was set above the ordered two liters per minute and no adjustment was made at that time. Review of a policy titled, Administration of Oxygen, dated 12/13/24 revealed oxygen was to be administered as ordered by the physician and equipment was to be maintained in a clean and sanitary manner when not in use.