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	05/30/2024

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

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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 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** 45751 Based on record review, interview, and policy review the facility failed to address bed rails on the baseline care plan. This affected one (Resident #196) of three residents reviewed for baseline care plans. The facility census was 39. Findings include: Review of medical record for Resident #196 revealed admitted [DATE] with diagnoses including wedge compression fracture of T 11-T 12 vertebra, displaced intertrochanteric fracture of left femur, cardiac arrhythmia's, dementia, depression, hypertension, pain, and unspecified fall. Review of the Minimum Data Set (MDS) assessment, dated 05/23/24, revealed the resident had severe cognitive impairment. Resident #196 required extensive assistance for activities of daily living. Review of baseline care plan dated 05/19/24 revealed no mention of the use of bed rails/mobility bars to the bed. Review of care plan revealed on 05/29/24 in Resident #196 profile care guide was added for walking/mobility devices: may use mobility bars as enabler for safe transfers or increased mobility. No care plan was added to address the actual use of mobility bars and interventions as to what to monitor. During interview on 05/30/24 at 2:45 P.M., MDS Support #147 verified enabler/mobility bars was not checked on the baseline care plan on admission. Review of policy titled Comprehensive Care Plan Guideline revised on 05/22/18 revealed a 48-hour baseline care plan will be completed within 48 hours of admission and will be the temporary working care plan until the comprehensive care plan is completed per guidelines.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, interview, and policy review, the facility failed to implement care plans regarding care needs for seven (Residents #27, #34, #36, #190, #194, #3, #13 and #28) residents. The facility census was 39. Findings include: 1. Review of medical record for Resident #27 revealed admitted [DATE] with diagnoses including syringomyelia and syringobulbia, ventricular tachycardia, Charocot's joint right elbow, spinal stenosis, anxiety, depression, chronic pain, hypertension, and localized swelling, mass and lump, unspecified upper limb. Review of care plan revealed no interventions regarding the use of mobility bars or interventions that can be reviewed and what the facility was monitoring. 2. Review of medical record for Resident #34 revealed admitted [DATE] with diagnoses including fracture of superior rim of right pubis, fracture of sacrum, atrial fibrillation, mantle cell lymphoma, malignant neoplasm of breast, anemia, hypertension, and pain. Review of MDS assessment dated [DATE] revealed the resident was cognitively intact. The resident required extensive assistance for ADL. Review of care plan revealed no interventions regarding the use of psychotropic medications or the use of mobility bars or what the facility was monitoring. 3. Review of medical record for Resident #36 revealed admitted [DATE] with diagnoses including but not limited to nondisplaced trimalleolar fracture of right lower leg, atrial fibrillation, cardiomegaly, intervertebral disc degeneration lumbar region, and hypertension. Review of MDS dated [DATE] revealed the resident was cognitively intact. Resident #36 required extensive assistance for ADL. Review of care plan revealed no interventions regarding the use of mobility bars and what the facility is monitoring. The care plan profile guide contained intervention walking/mobility devices: wheelchair, may use mobility bars as enabler for safe transfers or increased mobility. 4. Review of medical record for Resident #190 revealed admitted [DATE] with diagnoses including but not limited to fracture of neck of left femur, urinary tract infection, congestive heart failure, anemia, anxiety, irritable bowel syndrome without diarrhea, hemorrhoids, and personal history of malignant neoplasm of kidney. Review of MDS dated [DATE] the resident had severe cognitive impairment. The resident required extensive assistance for ADL. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of care plan revealed on interventions regarding psychotropic drug use or the use of mobility bars or what the facility was monitoring. 5. Review of medical record for Resident #194 revealed admitted [DATE] with diagnoses including but not limited to sepsis, endocarditis, hypotension, dementia, anemia, mild cognitive impairment, suicidal ideation, and poisoning by 4-aminophenol derivatives accidental. Review of MDS dated [DATE] revealed Resident #194 was cognitively intact. Resident #194 required extensive assistance for ADL. Review of care plan revealed no interventions for mobility bars or psychotropic drug use or what the facility was monitoring. During an interview on 05/29/24 at 2:57 P.M., MDS Nurse #137 verified that the care plan and interventions for the psychotropic drugs for Resident #34, Resident #190 and Resident #194 were not in place. During an interview on 05/30/24 at 12:34 P.M., Director of Nursing (DON) and Corporate Registered Nurse (CRN #145) verified that there were no care plans for side rails to include what will be monitored. CRN #145 stated the care plans use the terminology of may use side rails in case the facility/resident decided they did not want side rails they would not have to change the care plan. Both verified the care plans did not include the actual use of the side rails for the residents. Review of the policy titled Guidelines for Restraint/Enabler Use, revised 12/31/23, revealed a comprehensive care plan shall be developed that addresses medical symptoms, safety issues because of restraint/enabler use, based on informed choice with the risks and benefits explained, an observation trilogy informed consent for restraint/enabler should be completed in the resident's electronic health record (EHR), identifies measures to minimize the risk of resident decline and maintain strength and mobility, is reviewed as necessary, at least quarterly. 44070 6. Record review for Resident #3 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, major depression, altered mental status, dysphagia, cognitive communication deficit. Review of the MDS assessment dated [DATE] revealed Resident #3 was cognitively impaired. Resident #3 had a physician order dated 03/19/24 to take out hearing aides every evening and an order dated 05/09/24 to place hearing aides in ear every morning. Resident had one for both ears and informed staff to listen for a whistle and if a whistle was not heard to change the battery. Review of the care plan revealed the resident had hearing loss. Hearing aides were not included on the care plan and no interventions on monitoring hearing loss and hearing aides was available. During an interview on 05/30/24 at 10:38 A.M., Resident #3's representative stated the resident wore hearing aides. She stated she had a care meeting with the facility and asked for them to ensure staff to put in hearing aides and ensure they have active battery life. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/30/24 at 1:33 P.M., the DON stated she thought a care plan was in place as the orders had been changed recently regarding the hearing aide placement. The facility was unable to provide evidence of a care plan for hearing loss or hearing aides. 49039 7. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnosis that included osteoporosis, muscle weakness, hemiplegia, and hemiparesis. Review of MDS quarterly assessment completed on 01/21/24 revealed Resident #13 was dependent with toileting, showering, dressing and ambulation. Resident #13 was severely cognitively impaired. Review of the occupational therapy plan dated 03/21/24 revealed Resident #13 was to tolerate wearing a splint on her left hand/wrist for four hours per day with a target date of 05/15/24. Review of skilled services note for 05/14/24 revealed orthotic management was in place at this time due to contracture management and to decrease risk of skin breakdown. Review of the physician order dated 05/14/24 revealed an order for a left hand/wrist splint for six hours per day. Review of the care plan for Resident #13 revealed this resident has impairment in functional status related to decreased mobility and dependence in mobility. Review of care plan revealed no information regarding a splint. During an interview on 05/30/24 12:56 P.M., the DON , Corporate Nurse #145 and Assistant Director of Health Services #62 verified Resident #13's care plan was not updated to reflect current splint use. 8. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses that included encephalopathy, Parkinson disease, depression, insomnia, altered mental status and repeated falls. Review of Resident #28's elopement admission assessment completed on 07/24/23 revealed unknown elopement risk per family, states he lives alone and they are unaware of elopement risk. Review of care plan dated 01/10/24 for Resident #28 dated 07/31/24 revealed this resident was at risk for cognitive status decline. Nursing interventions included assess for change in level of consciousness. Review of the MDS quarterly assessment dated [DATE] revealed this resident was moderately cognitively impaired, did not wander, and wanderguard was not implemented. Review of physician order dated 04/15/24 revealed change wander device one month before expiration date. Review of physician order dated 05/20/24 check function and placement of wandering alter bracelet/device daily. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress notes dated 05/13/25 revealed Resident #28 wheeled himself down the service hallway and out the service door. Resident #28 walked 15 feet into the parking lot, when found he was escorted back into building and put with staff with one to one care. Review of exit seeking event report dated 05/15/24 revealed Resident #28 was seen exiting the building, change in plan of care was initiated with wandering alert device applied and one to one observation implemented. During an observation on 05/29/24 at 11:01 A.M., Licensed Practical Nurse (LPN) #125 confirmed Resident #28 had a wander guard implemented due to elopement risk. During an interview on 05/30/24 12:56 P.M., the DON, Corporate Nurse #145 and Assistant Director of Health Services #62 verified Resident #28 was seen exiting the building and the care plan was not updated to reflect current wandering behaviors. Record review of elopement policy dated 12/31/23 revealed staff are required to implement elopement interventions and update the residents care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, record review and interview, the facility failed to ensure a resident was assessed prior to removal of a Wanderguard bracelet. This affected one (Resident 321) of two residents reviewed for wandering and elopement. The facility census was 39. Findings include: Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included dementia, heart disease, edema, cognitive communication deficit and muscle weakness. Review of care plan dated 06/30/22 revealed resident was at risk of elopement and wandering with intervention for a Wanderguard bracelet to the right wrist for exit seeking behaviors entered on 08/24/22. Review of Physician order dated 01/12/24 stated to check function of wander alert bracelet daily. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was severely cognitively impaired. Review of the assessment dated [DATE] documented Resident #21 remained at risk for elopement and the current intervention, a Wanderguard bracelet, was left in place. Review of a progress note dated 05/17/24 documented Resident #21's Wanderguard bracelet was removed. The note did not specify reasoning or what precipitated the removal. During an interview on 05/29/24 at 12:06 P.M., Registered Nurse (RN) #118 stated Resident #21 may have had the Wanderguard bracelet removed. She was unsure why it was removed and confirmed facility had no assessment prior to removal that showed Resident #21 was no longer an elopement risk. RN #118 went to Resident #21 and checked her arms and legs and confirmed no Wanderguard bracelet was in place. During an interview on 05/29/24 at 4:33 P.M., the Administrator, Director of Nursing (DON), Assistant DON #62, and Corporate Nurse #145 confirmed facility had no documentation of Resident #21 being reassessed for elopement risk prior to the Wanderguard bracelet being removed. Review of facility policy titled, Elopement Risk Assessment and Prevention dated 12/31/23 revealed facility would assess residents for elopement risk upon admission, quarterly and upon change in condition.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, observations and interview the facility failed to ensure a the correct catheter bag was used to prevent urine reflux into Resident #28 bladder. This affected one (Resident #28) of three residents reviewed for urinary catheters. The facility census was 39. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE] with a primary diagnosis of urinary tract infection as secondary diagnoses of infection and inflammatory reaction due to indwelling urethral catheter, chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms and retention of urine. Review of admission assessment completed on 05/25/25 revealed Resident #28 has a urinary catheter. Direct care staff were required to monitor for signs of infection or worsening infection, and he required assistance or supervision for transfer and ambulation. Review of Resident #28's care plan with a start date of 05/28/24 revealed this resident uses a foley catheter for diagnosis of obstructive uropathy and direct care staff should maintain a closed system with urinary bag below the resident's bladder. Observation of Resident #28 on 05/29/24 at 10:10 A.M. and 2:01 P.M. revealed this resident was laying in bed with a leg bag at bladder level. Observation of the tubing revealed the urine was not flowing freely into the catheter bag. During an interview on 05/29/24 at 2:01 P.M., Registered Nurse (RN) #118 stated the facility does not provide leg bags and the bag was from his most recent hospital discharge on 05/25/24. The nurse confirmed the leg bag should have been switched over to a regular catheter bag. She confirmed that Resident #28 was still utilizing a urinary catheter leg bag and it was at bladder level. RN #118 confirmed the catheter should be below his bladder.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, interview, and policy review the facility failed to assess and/or obtain consents or orders for the use of bed rails. This affected six (Residents #27, #34, #36, #190, #194, and #196) of six reviewed for bed rails. The facility identified 29 residents who use side rails. The facility census was 39. Findings include: 1. Review of medical record for Resident #27 revealed admitted [DATE]. Review of the Minimum Data Set (MDS) assessment revealed the resident was cognitively intact. Resident #27 required extensive assistance to dependent on staff for activities of daily living (ADL) . Review of observations revealed bed rail assessment and bed rail informed consent were completed on 06/28/23. No further documentation or assessments completed after first assessment. Review of current physician orders revealed no order for bed rails. 2. Review of medical record for Resident #34 revealed admitted [DATE]. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. The resident required extensive assistance for ADL. Record review revealed no bed rail assessments or consent for enabler/mobility bars. Review of current physician orders revealed no order for bed rails. 3. Review of medical record for Resident #36 revealed admitted [DATE]. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. Resident #36 required extensive assistance for ADL. Record review revealed no bed rail assessments or consent for enabler/mobility bars. Review of current physician orders revealed no order for bed rails. 4. Review of medical record for Resident #190 revealed admitted [DATE]. Review of the MDS dated [DATE] revealed the resident had severe cognitive impairment. The resident required extensive assistance for ADL. Record review revealed no bed rail assessments or consent for enabler/mobility bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current physician orders revealed no order for bed rails. 5. Review of medical record for Resident #194 revealed admitted [DATE]. Review of the MDS assessment dated [DATE] revealed Resident #194 was cognitively intact. Resident #194 required extensive assistance for ADL. Record review revealed no bed rail assessments or consent for enabler/mobility bars. Review of current physician orders revealed no order for bed rails. 6. Review of medical record for Resident #196 revealed admitted [DATE]. Review of the MDS dated [DATE] revealed Resident #196 had severe cognitive impairment. Resident #196 required extensive assistance for ADL. Record review revealed no bed rail assessments or consent for enabler/mobility bars. Review of current physician orders revealed no order for bed rails. During an interview on 05/29/24 at 8:24 A.M., the Director of Nursing (DON) verified the bed rail assessments and consents are located under the observation tab in the electronic health record. During an interview on 05/29/24 at 1:50 P.M., the DON verified that no bed rail assessments were located in the electronic health record. Review of policy titled Guidelines for Restraint/Enabler Use, dated 12/31/23, revealed each resident will have an individualized nursing observation upon admission, quarterly, and as needed that shall address the need for a safety device, medical symptom for use of the device and identification of whether the device restricts movement or limits the resident from doing something they could previously do. An order shall be obtained that specifies the type of restraint/enabler and reason for use, a comprehensive care plan shall be developed that addresses medical symptoms, safety issues because of restraint/enabler use, based on informed choice with the risks and benefits explained, an observation trilogy informed consent for restraint/enabler should be completed in the resident's electronic health record (EHR), identifies measures to minimize the risk of resident decline and maintain strength and mobility, is reviewed as necessary, at least quarterly.

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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** 45751 Based on record review, observation, interview and manufacturer's instruction review, the facility failed to prime an insulin pen prior to administration, resulting in a signficant medication error. This affected one (Resident #23) of five residents observed during medication pass. The facility census was 39. Findings include: Review of medical record for Resident #23 revealed admitted [DATE] with diagnoses including type two diabetes. During an observation on 05/29/24 at 11:27 A.M., Licensed Practical Nurse (LPN) #115 was preparing to give Resident #23 six units of lispro insulin. LPN #115 dialed up six units of insulin without priming the insulin pen. LPN #115 then administered the insulin to Resident #23. During an interview on 05/29/24 at 11:35 A.M., LPN #115 verified she did not prime the insulin pen prior to administering the insulin to Resident #23. LPN #115 stated she did not know that she was supposed to prime the pen. Review of insulin lispro KwikPen insert on accessdata.fda.gov/drugsatfda_docs/label revealed prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime the pen, turn the dose knob to select 2 units. Hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, continue holding the pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count slowly to 5. You should see insulin at the tip of the needle. If you do not see insulin, repeat the priming steps, but not more than 4 times. If you still do not see insulin, change the needle and repeat the priming steps.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, interview, and policy review the facility failed to ensure medications were not left at the bedside. This affected one (Resident #30). The facility identified four mobile cognitively impaired residents (#3, #26, #28, and #248) in the facility. The facility census was 39. Findings included: Review of medical record for Resident #30 revealed admitted [DATE] with diagnoses including multiple sclerosis, anemia, shock, gastrointestinal hemorrhage, sepsis, hypertensive heart disease with heart failure, congestive heart failure, non-ST elevations (NSTEMI) myocardial infarction, pleural effusion, and cardiomyopathy. Review of minimum data set (MDS) dated [DATE] revealed a which indicated Resident #30 was cognitively intact. Review of current physician orders revealed that from 7:00 P.M.-11:00 P.M. the following medications were to be administered: Atorvastatin 80 milligrams (mg) (cholesterol), carvedilol 3.125 mg (heart), entresto 24-26 mg (heart), hydroxyzine 25 mg (itching), and melatonin 6 mg. Review of Medication Administration Record (MAR) for May 2024 revealed the above six medications were marked as given by the nurse on 05/28/24. During an observation on 05/29/24 at 7:52 A.M., there were medications in medication cup at bedside for Resident #30. Six medications were in the cup. Resident #30 was not in the room. During an interview on 05/29/24 at 7:53 A.M., Licensed Practical Nurse (LPN) #115 verified that six pills were left on the overbed table in Resident #30's room and the resident was not in the room. LPN #115 stated she did not pass his medications. During an interview on 05/29/24 at 8:24 A.M. the Director of Nursing (DON verified the medications were from the night shift medication pass. Review of policy titled Medication Administration General Guidelines revised January 2018 revealed the resident is always observed after the administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44070 Based on record review, interview and policy review, the facility failed to maintain a water management plan that included monitoring measures and acceptable ranges and failed to identify the presence of abnormal test results and take appropriate action. This had potential to affect all facility residents. The facility census was 39. Findings include: Review of microbiological analyses dated 01/25/24 of the water system revealed lab results should be maintained between 0.1 and 0.9. Of 14 areas tested in the nursing facility, two had abnormal reading and should have had site flushing and consider disinfection and five areas had abnormal readings and should have had site flushing and immediate site disinfection. Several areas of the connected assisted living were also tested with five of six testing in the abnormal range requiring flushing and disinfection. Review of the Legionella Water Management Plan dated 03/05/24 revealed monthly testing would be completed of the cold and hot water for hardness, total alkalinity and ph testing, water temperatures shall be done weekly and visual inspections should be done of the sinks showers and toilets daily. The plan did not include information on the acceptable ranges for each measure. Review of facility documentation revealed some weekly temperatures were logged but no range of acceptable limits and no evidence of monthly testing of water hardness, alkalinity and PH testing were found or provided. During an interview on 05/29/24 at 12:35 P.M., Corporate Maintenance (CM) #146 stated the facility completed testing and confirmed if over 9.9 should complete flush and retest if over 10 should complete flushing and disinfectant. CM revealed facility did not complete any flushing or disinfectant and confirmed abnormal test results up to 248. CM confirmed they needed to get lab results from GFS (contracted water testing company), but stated he was unsure what information the lab company would be able to provide. He also revealed facility should have acceptable ranges for all the testing measures, but was unable to provide upon request. CM confirmed the facility water management plan did not include specific measures or ranges staff look for or interventions if outside the acceptable ranges. Review of the facility policy titled Guidelines for Water Management, dated 12/31/23, revealed facility shall establish procedures to reduce the risk of Legionella in the facilities water system. The policy stated based on the risk assessment, control measures would be established to address potential hazards. Testing protocols and acceptable ranges would be established for each measure. The individual responsible would document findings. If control limits (ranges) were not maintained, corrective actions would be taken and documented.

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	05/30/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, interview and policy review the facility failed to ensure signed consents were completed and vaccinations were administered timely for pneumonia and flu vaccines. This affected three (Residents #14, #25, and #28) of five residents revealed for vaccinations. Facility census was 39. Findings include 1. Review of the medical record for Resident #28 revealed an admitted [DATE]. Review of the vaccination consents dated 07/25/23 revealed Resident #28 consented to have the flu vaccine administered. Review progress notes dated 08/14/24 revealed a phone call to the resident's responsible party who agreed to Resident #28 receiving the pneumonia vaccine. The vaccine was given Pneumonia was given on 08/19/23. Review of the vaccination consents dated 10/20/23 revealed Resident #28 consented to have the flu vaccine administered. The flu vaccine was administered on 10/30/23. 2. Review of the medical record for Resident #14 revealed an admitted [DATE]. Review progress notes dated 06/28/23 revealed the resident's responsible party was contacted regarding an order for a pneumonia vaccine. The vaccination was given on 06/28/23. The facility was unable to provide evidence of any consent being signed for the pneumonia vaccination. 3. Review of the medical record for Resident #25 revealed an admitted [DATE]. Review of the vaccination consents dated 11/01/23 revealed Resident #25 consented to have the pneumonia vaccine administered. Review of vaccination administration record revealed no evidence the pneumonia vaccine was administered. The administration record stated this vaccine was refused, but no notation or consent was refused. During an interview on 05/29/24 at 3:01 P.M., Assistant Director of Nursing (ADON) #62 stated the facility was unable to provide evidence Resident #25 received the pneumonia vaccine or that consents had been signed for Residents #28 and #14. Review of facility policy titled, Influenza, Pneumococcal and COVID-19 Immunizations, dated 12/31/23 revealed Resident or representative would complete a signed an informed consent indicating acceptance/refusal of immunization. A copy shall be retained in the medical record. The policy also stated each resident shall receive the immunization per resident/representative request.