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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and policy review the facility failed to ensure infection control procedures were followed for laundry which had the potential to affect all 52 residents residing in the facility. Additionally, the facility failed to ensure infection control was followed for wound care for one (Resident #12) out of three residents reviewed for pressure ulcers. Lastly, the facility failed to follow infection control procedure for indwelling urinary catheter care for one (Resident #02) out of one resident reviewed for catheter care. The facility census was 52.1.Interview on 03/25/26 from 8:10 A.M. to 8:20 A.M. with Director of Housekeeping #655, revealed the facility's normal laundry process included aides placing laundry in dirty linen rooms and housekeeping staff collecting the items using personal protective equipment (PPE), then separating, washing, drying, and delivering the clean laundry items. Director of Housekeeping #655 stated PPE was worn during collection and separation. When asked about isolation procedures, Director of Housekeeping #655 stated housekeeping staff only retrieved laundry from dirty linen rooms and aides were responsible for separating laundry from contact isolation rooms. During the same interview Housekeeping Staff #33 revealed aides did not separate clothing from contact isolation rooms or from incontinence episodes prior to placing items in the dirty linen rooms and laundry staff could not determine which items needed to be washed separately. Interview on 03/25/26 at 8:23 A.M. with Certified Nursing Assistant (CNA) #364 revealed aides placed laundry from isolation rooms into standard trash bags rather than yellow isolation bags. She stated items with blood were placed in red biohazard bags and taken directly to laundry. Interview on 03/25/26 at 8:25 A.M. with CNA #176 revealed dirty linen, including linen from contact isolation rooms, was placed in standard trash bags with no identifying differences and taken to the dirty linen room. She stated only items with blood were placed in red bags. Interview on 03/25/26 at 8:29 A.M. with CNA #569 revealed staff were expected to place isolation laundry in yellow bags and transport soiled items separately. Interview on 03/25/26 at 8:43 A.M. with CNA #569 revealed she was unable to locate any yellow isolation bags in the facility. CNA #569 attempted to locate yellow bags in the soiled linen room, outside of two active contact isolation rooms, in the laundry room, and in two additional soiled linen rooms. Yellow isolation bags were not available in any of these locations and CNA #569 stated there would be no additional locations to find the yellow isolation bags. 2. Review of the medical record for Resident #12 revealed an admission date of 12/22/23. Diagnoses included malignant neoplasm of part of the right bronchus or lung, severe protein calorie malnutrition, chronic respiratory failure with hypoxia, and sepsis. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the annual Minimum Data Set (MDS) 3.0 assessment for Resident #12, dated 01/11/26, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired. The assessment indicated the resident was dependent on staff for most activities of daily living and had a pressure ulcer requiring treatment. Review of physician orders for Resident #12 revealed a wound care order dated 03/06/26 to cleanse the right pinky plantar wound with wound cleanser or normal saline, pat dry, apply hydrogel, cover with an abdominal dressing, and wrap with kerlix from toes to knee, to be completed every other day through 03/19/26. Review of physician orders further revealed a wound care order dated 03/19/26 to cleanse the right pinky plantar wound with wound cleanser or normal saline, pat dry, wrap with an unna boot and kerlix from toes to knee, to be completed every three days and as needed if dislodged or soiled, ongoing. Review of the plan of care for Resident #12, initiated 07/29/25, revealed the resident required enhanced barrier precautions during high contact care related to the presence of a wound with dressing changes. Interventions included performing hand hygiene before and after care, utilizing personal protective equipment including gown and gloves, and following infection control practices per policy. Observation on 03/25/26 at 2:03 P.M. of a wound dressing change performed by Wound Nurse (WN) #570, with Registered Nurse (RN) #284, and Certified Nursing Assistant (CNA) #364 revealed multiple and repeated breaches in infection control practices. WN #570 donned gloves without performing hand hygiene and immediately touched multiple surfaces including the door, personal protective equipment storage on the door, and the bedside tray before initiating care, WN # 570 did not remove the gloves that had touched all the environmental surfaces or perform hand hygiene prior to starting the wound care procedure. WN #570 removed the resident's boot and used scissors that were placed on a chair. The scissors were repeatedly placed on and retrieved from the chair and later from the windowsill without being cleaned. WN #570 then touched the open wound on the right foot with contaminated gloves after contacting environmental surfaces. During the procedure, both WN #570 and RN #284 were observed touching the open wound multiple times with the same pair of gloves after touching soiled surfaces. RN #284 held and repositioned the resident's foot while her gloved hands made direct contact with the wound area and surrounding skin. She then used the same gloves to adjust room equipment, including turning off heat in the room, and resumed contact with the resident's wound without changing gloves. WN #570 placed a washcloth into water and cleansed the wound using the same gloves that had contacted multiple surfaces. The same washcloth and gloves were then used to clean other areas of the resident's legs that had skin areas from previous impetigo. WN #570 then returned to the wound on the right foot and continued cleansing with the same contaminated gloves and washcloth. Moisture and drainage from the leg wounds were observed transferring onto linens beneath the resident. After removing gloves and performing hand hygiene once, WN #570 donned a new pair of gloves and immediately touched the outside of a medication container and supply packaging. Without changing gloves, she applied medication directly to the resident's skin and wound areas with soiled gloves. RN #284 used scissors that had been sitting on the windowsill to open clean dressing supplies, and the same scissors were used to cut clean dressing materials. At approximately 2:10 P.M., CNA #364 entered the room, donned personal protective equipment without performing hand hygiene, applied gloves, and then handled the resident's foot during the wound care process. During the dressing application, WN #570 handled both clean and previously used materials with the same gloves, including reusing an ace wrap, and continued wrapping the resident's leg after contacting soiled surfaces. WN #570 donned new gloves at one point without performing hand hygiene prior to application and continued the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/25/26 at 2:30 P.M. with WN #570 confirmed the observed wound care process as described with the breaks in infection control. Review of a policy titled, Guideline for handwashing/hand hygiene, dated 11/18/25, revealed staff were required to perform hand hygiene before and after patient contact, change gloves between tasks, maintain clean and sterile technique when performing wound care, and prevent cross contamination by avoiding contact between contaminated and clean surfaces or supplies. 3.Resident #02 was admitted on [DATE] with diagnoses of mechanical complication of indwelling urethral catheter, neuromuscular dysfunction of bladder, and calculus (stone) of kidney. Review of the Resident #02 's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident used indwelling urinary catheters and had moderate cognitive impairment. Review of the medical record for Resident #02 revealed an order written 02/25/26 for Foley catheter care every shift (twice a day) with special instructions to monitor proper placement of leg securement device. Observation of Resident #02 in his room on 03/25/26 at approximately 11:39 A.M. on 03/25/26 revealed the resident was lying in bed. The Foley catheter drainage bag was resting on the floor on the right side of the Resident inside an outer blue urinary drainage bag holder. Certified Nurse Aide (CNA) #176 came in the residence room about 11:53 A.M. on 03/25/26 to perform Foley catheter care. The Resident was moved to the bathroom for Foley catheter care. After Foley catheter care the Resident was placed back in bed. The Foley catheter bag was placed resting on the floor on the right side of the Resident inside a blue urinary drainage bag holder. Interview with CNA #176 on 03/25/26 at approximately 12:10 P.M. confirmed the Foley catheter bag was resting on the ground inside the blue urinary drainage bag holder. At 12:19 P.M. on 03/25/26 the Director of Health Services (DHS) #377 was interviewed in the Resident's room. DHS #377 confirmed the Foley catheter bag was resting on the floor, but not directly, as it was inside the blue urinary drainage bag holder. DHS #377 provided product information on the urinary drainage bag holder at 8:19 A.M. on 3/26/26. Review of the provided product information of the urinary drainage bag holder documented the holder is designed to hang from wheelchairs, geriatric chairs, or bed rails. The urinary drainage bag holder is of heavy vinyl material with welded seam construction, and its purpose is to protect urinary drainage bags from accidental leakage and damage. Review of the Facility Clinical Standard Operating Procedure (SOP) titled Urinary Catheter Care (reviewed 12/16/24) revealed the guidance for staff in the SOP stated to be sure the catheter tubing and drainage bag are kept off the floor. The United States Center for Disease Control (CDC) Guideline for Prevention of Catheter Associated Urinary Tract Infection 2009 was reviewed. In the section titled Proper Technique for Urinary Catheter Maintenance, a recommendation was to not rest the (urinary drainage) bag on the floor.

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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. This deficiency represents non-compliance investigated under Complaint Number 1404883.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, staff interview, and facility policy review, the facility failed to follow care instructions for nephrostomy care for Resident #02. This affected one resident (Resident #02) of three residents investigated for urinary catheters. The facility census was 52.Findings include:Resident #02 was admitted on [DATE] diagnoses include mechanical complication of indwelling urethral catheter, neuromuscular dysfunction of bladder, and calculus (stone) of kidney.Review of the Resident #02's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident used indwelling urinary catheters and had moderate cognitive impairment. Resident #02 was discharged from hospital on [DATE] after insertion of a right nephrostomy tube. Review of Resident #02's care instructions included nephrostomy tube care at the time of the hospital discharge. The care instructions stated to clean around the (nephrostomy) tube and change the dressing daily or as instructed by your care team and also to change the dressing if it becomes wet or dirty.Review of the Resident #02's medical record revealed the resident re-admitted to the facility on [DATE]. Review of the medical record between 12/16/25 and 01/21/26 revealed no orders to change the dressing around the nephrostomy site. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) between 12/16/25 and 01/21/26 found no documentation of dressing changes being completed for Resident #02 around the nephrostomy site. Interview on 03/26/26 at approximately 11:32 A.M. with the Director of Health Services #377 confirmed there were no documented occurrences of dressing changes around the nephrostomy site for Resident #02 between 12/16/25 and 01/21/26.Review of facility clinical standard operating procedure (SOP) titled Urinary Catheter Care (reviewed 12/16/24) does not define a minimum frequency of dressing changes for catheter sites. The SOP advises staff to determine if changes in daily urinary catheter care procedures have been made.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on record review, resident interview, and staff interview the facility failed to ensure a specialist appointment was scheduled for one (Resident #12) out two residents reviewed for activities of daily living. The facility census was 52.Review of the medical record for Resident #12 revealed an admission date of 12/22/2023. Diagnoses included but not limited to polyneuropathy, contracture of right knee, contracture of left knee, and contracture of muscle of left upper arm.Review of the annual Minimum Data Set (MDS) 3.0 assessment for Resident #12, dated 01/11/2026, revealed a Brief Interview for Mental Status score of 12, indicating the resident was cognitively intact. The assessment indicated the resident required extensive to total assistance with activities of daily living including dressing, hygiene, and mobility, placing the resident at risk for complications related to immobility and contractures.Review of physician orders for Resident #12 revealed orders dated 02/01/2025, 10/10/2025, and 12/19/2025 for a consult with a community provider for Physical Medicine and Rehabilitation for evaluation and treatment related to weakness and contractures.Review of the plan of care for Resident #12 revealed problems related to pain and decreased participation in activities due to physical limitations including contractures. The plan of care did not include interventions related to splint use, management of contractures, or follow up for specialty consultation related to contractures.Review of therapy documentation and interviews revealed on 03/24/2026 at 10:30 A.M., Rehabilitation (Rehab) Director (RD) #650 stated the resident had confirmed wrist contractures. The Rehab Director stated that during evaluation the resident was unable to tolerate splinting or stretching to the wrists. The Rehab Director further stated a splint representative was brought in and determined due to the severity of range of motion impairment, no splint could be applied. The Rehab Director stated there were no further recommendations for the resident's wrist contracture and confirmed the Nurse Practitioner was aware of these findings.Review of therapy interview on 03/24/2026 at 2:52 P.M. revealed RD #650 stated the initial measurement of the resident's left wrist flexion contracture was -70 degrees and remained unchanged throughout subsequent sessions.Review of nursing progress notes for Resident #12 revealed on 11/20/2025 at 4:31 P.M., staff attempted to schedule an appointment for weakness and contractures as ordered and were informed the provider had retired and rescheduling at a different office may be required. The Nurse Practitioner and responsible party were notified. Review of documentation dated 12/31/2025 revealed staff spoke with the community provider for Physical Medicine and Rehabilitation regarding scheduling, and the facility was informed an appointment would not be scheduled due to prior attempts and reported refusals. No documentation was identified to support resident refusals.Observation on 03/23/2026 at 12:58 P.M. revealed Resident #12 had contractures of the bilateral wrists with multiple fingers locked in place. Resident #12 stated he believed he had splints but did not know where they were and reported the facility was not addressing his contractures. Resident #12 further stated he had not been sent to a specialist and was told the only option was in another city.Interview on 03/24/2026 at 1:51 P.M. with Resident #12 revealed he had been provided a phone number on that date to schedule the appointment. Resident #12 stated he had not previously been provided a contact number and reported receiving one automated call from the specialist but did not understand how to schedule the appointment. Resident #12 stated he required assistance from the facility to schedule the appointment and reported no follow up assistance was provided.Interview on 03/24/2026 at 1:36 P.M. with Registered Nurse (RN) #366 revealed the facility attempted to schedule a specialist appointment, however, the community provider of Physical Medicine and Rehabilitation declined to schedule due to reported prior refusals. The staff member stated there was no documentation available to support the alleged refusals.Interview on 03/24/2026 at 2:33 P.M. with Director of Nursing (DON) revealed there was no evidence of additional attempts to schedule the specialist appointment for Resident #12's (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contractures. The Director of Nursing was unable to identify the initial date of referral or explain the gap between attempts to schedule the appointment. The Director of Nursing stated the facility would assist with transportation but acknowledged uncertainty regarding whether Resident #12 understood the need to arrange transportation. The Director of Nursing confirmed the facility did not follow up to assist Resident #12 in scheduling the appointment.

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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. This deficiency represents non-compliance investigated under Complaint Number 1404883.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure antibiotic stewardship was followed for two (Residents #11 and #12) out of four residents reviewed for antibiotic stewardship. The facility census was 52. 1.Review of the medical record for Resident #11 revealed an admission date of 02/04/26. Diagnoses included dementia, pulmonary fibrosis, anxiety, and pleural effusion.Review of the five-day Minimum Data Set (MDS) 3.0 assessment for Resident #11, dated 02/10/26, revealed a Brief Interview for Mental Status score of 10, indicating the resident had moderate cognitive impairment.Review of physician orders for Resident #11 revealed an order dated 03/09/26 for Levofloxacin (antibiotic) 500 milligrams by mouth once daily for a urinary tract infection through 03/11/26. Review of physician orders further revealed an order dated 02/04/26 indicating urine may be dipped for signs and symptoms of urinary tract infection and sent for culture and sensitivity if leukocytes were present.Review of clinical documentation revealed a late entry progress note dated 03/06/26 at 2:30 P.M. indicating the resident reported urinary frequency and cloudy urine. The Nurse Practitioner (NP) was notified and a urine analysis with culture and sensitivity was ordered.Review of laboratory results dated [DATE] revealed a urine culture positive for 50,000 to 100,000 Klebsiella aerogenes.Review of the NP progress note dated 03/09/26 revealed the resident reported urinary frequency and urgency described as needing to urinate again approximately 15 minutes after voiding with only small amounts of urine output. The resident denied fever, chills, flank pain, suprapubic pain, dysuria, hematuria, or other systemic signs of infection. Physical assessment revealed no suprapubic tenderness or costovertebral angle tenderness. The NP documented urinary tract infection and initiated Levofloxacin 500 mg daily for three days. The note referenced McGeer criteria as being met based on urinary frequency, urgency, and urine culture results.Interview on 03/24/26 at 11:15 A.M. with Assistant Director of Nursing (ADON) #570 confirmed the urinary tract infection did not meet McGeer criteria. ADON #570 stated the NP documentation was referenced as justification for antibiotic initiation; however, staff were aware the clinical criteria for McGeer were not actually met based on the resident's symptoms.Interview on 03/24/26 at 11:15 A.M. with Director of Nursing revealed awareness that antibiotics were being prescribed in situations where McGeer criteria were not met, even when provider documentation indicated criteria were met.2. Review of the medical record for Resident #12 revealed an admission date of 12/22/23. Diagnoses included malignant neoplasm of part of right bronchus or lung, severe protein-calorie malnutrition, aneurysm of other specified arteries, and enterocolitis due to Clostridium difficile not specified as recurrent.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment. The MDS further revealed the resident was frequently incontinent of bladder and always incontinent of bowel.Review of infection surveillance documentation revealed an infection tracker entry indicating a urinary tract infection was present and McGeer criteria were documented as being met based on urine culture colony count thresholds of ˆ100,000 CFU/mL.Review of laboratory results dated [DATE] revealed urine culture results of 10,000-50,000 CFU/mL growth of Proteus mirabilis, Pseudomonas aeruginosa, and Enterococcus faecalis. The culture results were below the ˆ100,000 CFU/mL threshold referenced in the infection tracker documentation and did not meet the documented criteria used to justify infection classification.Review of a provider progress note dated 11/24/2025 revealed the Nurse Practitioner (NP) documented urinary tract infectious disease after the resident reported urinary frequency and intermittent dysuria. The NP noted the resident was high risk for progression to severe infection due to a history of septic UTI and initiated Levofloxacin for three days. The note referenced McGeer criteria as being met, however, supporting laboratory results did not align with the stated threshold, and clinical symptoms documented were non-specific and insufficient alone to meet McGeer surveillance criteria.Interview on 03/26/26 at 11:04 A.M. with Assistant Director of Nursing (continued on next page)

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

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ADON) #570 revealed the November UTI did not meet McGeer criteria. ADON #570 stated the infection tracker incorrectly reflected ˆ100,000 CFU/mL and confirmed the actual culture results were significantly lower. ADON #570 further stated concerns had been previously discussed with the Nurse Practitioner regarding antibiotic initiation without meeting McGeer criteria.Interview on 03/26/26 at 11:04 A.M. with DON confirmed the November UTI episode did not meet McGeer criteria based on culture results and resident presentation. DON confirmed staff awareness of ongoing concerns regarding antibiotic initiation when criteria were not met.