STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365571	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Portage Valley	20311 Pemberville Rd Pemberville, OH 43450

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, observation, and staff interviews, the facility failed to ensure a resident who was dependent on staff for eating was assisted with eating with her meal. This affected one (Resident #16) of one resident observed for eating and had the potential to affect eight residents (#2, #4, #14, #28, #30, #31, #42, and #43) the facility identified as requiring assistance with eating. The facility census was 49. Findings include: Review of the medical record for Resident #16 revealed she was admitted on [DATE] with diagnoses of intracerebral hemorrhage with left sided paralysis and dysphagia. Review of the care plan revised 06/2024 revealed Resident #16 was care planned for Activity of Daily Living (ADL) self-care and/or physical mobility performance deficit. Interventions included to provide extensive assistance of one staff member for eating. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively impaired and dependent on staff assistance for eating. Review of the current physician orders for 07/2024 revealed Resident #16 was ordered a regular diet, mechanical soft with thin liquids. Review of the State tested Nursing Assistant (STNA) documentation sheet dated 07/22/24 and timed 9:45 A. M. and 2:03 P.M. for Resident #16 revealed she required total dependence for those meals, indicating full staff performance. Review of the nursing progress notes for Resident #16 revealed a nursing note dated 07/22/24 at 3:00 P.M. verifying the lunch tray for Resident #16 was left in her room and appearing untouched, and the silverware was still wrapped. The nursing progress note further stated the STNA was asked to heat the food for Resident #16 and attempt to feed and her it was reported to the nurse Resident #16 ate 100% of her meal and drank 100% of her Ensure shake (a high calorie nutritional supplement). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/22/24 at 2:45 P.M. revealed the lunch tray for Resident #16 was left in her room on the overbed table. The lunch tray was sitting with the covered dome lid in place, the silverware rolled in linen napkin and completed rolled up, a glass of juice with a straw in the glass and a glass of white milk. Further observation revealed the food under the dome lid appeared to be untouched, there were no divots or smear marks on the plate indicating the food was touched or offered to Resident #16. Interview on 07/22/24 at 2:47 P.M. with Licensed Practical Nurse (LPN) #217 verified Resident #16's lunch tray remained on the overbed table and appeared to be untouched. Interview on 07/22/24 at 2:50 P.M. with STNA #219 stated she did not get in shift change report that Resident #16 did not eat lunch. Interview on 07/22/24 at 2:51 P.M. with LPN #217 stated it was not reported to her that Resident #16 did not eat lunch. Interview on 07/22/24 at 3:15 P.M. with STNA #219 stated Resident #16 ate and drank 100% of her lunch tray and 100% of her Ensure supplement. Telephone interview on 07/22/24 at 3:57 P.M. with STNA #206 stated she attempted to feed Resident #16 and at the time she refused, so she left the tray and meant to go back and attempt again but forgot and then her shift was over. Interview on 07/23/24 at 8:30 A.M. with the Administrator stated the facility does not have any policies related to feeding residents who were dependent on staff for eating and the facility applies the interventions in the care plan. Interview on 07/23/24 at 11:39 A.M. with STNA #232 stated extensive means the resident needs extensive assistance with feeding and the by one means only one person needs to assist. STNA #232 further stated that Resident #16 will assist at times but most of the time she was fed by the staff. This was an incidental finding discovered during the course of the complaint investigation.