

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Portage Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 44815 Based on medical record review, staff interview and review of facility policy, the facility failed to assess a newly identified bruise and further failed to ensure neurological assessments were completed following a head injury. This affected one (#11) of three residents reviewed for injuries. The facility census was 46. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses of dementia, anxiety, and osteoporosis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/10/25, revealed Resident #11 had impaired cognition. Review of the hospital discharge records, dated 02/05/25, revealed Resident #11 was assessed at the hospital after a fall on 02/05/25. The documents revealed a head computed tomography (CT) scan showed a small focus of isodense extra-axial fluid on the right side that was probably a small, subacute subdural hematoma (a collection of blood between the brain and the skull). The plan included follow up in about six weeks with a new head CT. Further review revealed Resident #11 was at risk for gradual expansion of the hemorrhage due to the prominence of the extra-axial spaces. Review of a progress note dated 02/18/25 revealed Resident #11 was observed with a new bruise on her left forehead. The progress note did not include an assessment or description of the new bruise. Review of a Weekly Skin Observation Tool, completed 02/18/25, revealed Resident #11 had a bruise to her left forehead. Further review revealed no additional description of the wound, including size, color, or any additional observable characteristics. Further review of Resident #11's medical record revealed no evidence neurological assessments were completed on 02/18/25 following the identification of the new bruise on the resident's forehead. Review of the facility's investigation revealed the facility determined Resident #11 received the bruise from lying in bed with her head pressed against the u-bar (a bar located near the head of the bed to assist residents with bed mobility). The facility's intervention was to pad the u-bars on Resident #11's bed. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		
Event ID:		
Facility ID: 365571		
If continuation sheet Page 1 of 7		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25 at 12:08 P.M. with the Director of Nursing (DON) revealed the facility had no guidance or protocol for assessing a new bruise. The DON stated each nurse assessed wounds differently and it was acceptable for one nurse to provide a description of the injury, including size, location, and color, while another nurse could assess the injury by simply stating a bruise was found. Interview on 03/04/25 at 12:29 P.M. with Nurse Practitioner (NP) #302 revealed he worked in the facility five days weekly. Further interview revealed NP #302 would expect a new bruise assessment to include its location, color, and estimated measurements. Interview on 03/04/25 at 1:39 P.M. with Licensed Practical Nurse (LPN) #201 confirmed she completed a skin assessment on Resident #11's wound on 02/18/25. LPN #201 stated she did not describe the bruise, including color or size, because she believed the assessment had been completed by the previous shift's nurse. A follow-up interview on 03/04/25 at 2:50 P.M. with the DON revealed neurological assessments were not completed for Resident #11 after the bruise on her forehead was identified because the bruise was not a hematoma. The DON stated she assessed the bruise and it was purple and flat and did not have a bump. The DON confirmed no description of the bruise was in Resident #11's record. Review of the facility policy titled, Skin Care Management, revised 11/17/22, revealed it was the policy of the facility to follow all applicable state and federal regulations regarding skin care management. Further review revealed the facility would implement, monitor and modify if needed appropriate strategies to attain or maintain intact skin; prevent complications; and promptly identify and manage complications. Review of the facility policy titled, Neurological Assessment, revised 03/19/21, revealed a neurological assessment should be initiated following any obvious head trauma. This was an incidental finding during the complaint survey completed on 03/04/25.		

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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** 44815 Based on medical record review, staff interview, review of electronic mail (e-mail) correspondence and review of facility policy, the facility failed to implement interventions to prevent a fall for one (#13) of three residents reviewed for falls. Additionally, the facility failed to complete neurological checks following an unwitnessed fall with injury and further failed to monitor injuries resulting from a fall per physician order. This affected one (#12) of three residents reviewed for falls. The facility census was 46. Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses of dementia and epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/28/25, revealed Resident #13 was rarely/never understood, was dependent for transfers and used a wheelchair for mobility. Review of a Fall Risk Screening, dated 09/30/24, revealed Resident #13 was at risk for falls. Review of a nursing progress note dated 12/16/24 revealed Resident #13 appeared to be sliding/moving forward in her wheelchair and therapy was to evaluate the wheelchair for proper seating. Further review of the medical record from 12/16/24 through 01/03/25 revealed no evidence Resident #13 was evaluated by therapy for proper wheelchair seating. Review of a nursing progress note dated 01/03/25 revealed Resident #13 slid from her wheelchair while seated in the dining room. Resident #13 had no injuries as a result of the fall. Review of an interdisciplinary team (IDT) note dated 01/07/25 revealed the team met to discuss Resident #13's fall and determined an intervention to evaluate Resident #13 for a new wheelchair. Review of Resident #13's current care plan revealed she was at risk for falls related to impaired mobility. A new intervention was initiated on 03/03/25 for staff to perform frequent checks on resident when in the wheelchair, and staff would boost the resident as needed. Observations of Resident #13 on 03/03/25 at 9:38 A.M., 10:26 A.M., and approximately 12:00 P.M., and on 03/04/25 at 8:37 A.M. revealed no concerns regarding Resident #13 being improperly positioned in her wheelchair. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/03/25 at approximately 12:30 P.M. with the Director of Nursing (DON) and concurrent review of the facility's fall investigation revealed Resident #13 was observed to slide from her wheelchair in the dining room by dietary staff on 01/03/25. Resident #13 sustained no injury due to the fall. The facility determined Resident #13's wheelchair should be evaluated by therapy to determine if a new wheelchair would be more appropriate. The DON stated Resident #13 often slid her bottom to the outside edge of the wheelchair and leaned back against the backrest. Further interview revealed Resident #13 was hospitalized from 02/21/25 to 02/25/25 due to a change in condition, before any changes to her wheelchair occurred. Resident #13 returned to the facility from the hospital and continued to use her wheelchair. The DON stated the family was waiting for test results before deciding whether to pursue a new wheelchair. The DON stated the fall intervention for the fall on 01/03/25 remained an assessment of Resident #13's wheelchair, once the family followed up with the facility with their decision. Upon further inquiry, the DON stated the interim fall intervention, implemented on 03/03/25, was to monitor and reposition Resident #13 as needed. Review of an e-mail correspondence dated 03/04/24 at 1:20 P.M. from Director of Rehabilitation (DOR) #303 revealed the therapy department did not receive a consultation to assess Resident #13's wheelchair on 12/16/24. Further review revealed the therapy department was notified on 01/08/25 (23 days after the need was identified on 12/16/24 and five days after the resident's fall on 01/03/25) regarding an evaluation of Resident #13's wheelchair. An occupational therapy (OT) evaluation was completed on 01/13/25 and therapy initiated the process for Resident #13 to receive a customized wheelchair; however, this process was placed on hold by the family following the resident's hospitalization . Interview on 03/04/25 at 3:57 P.M. with DOR #303 confirmed Resident #13 remained at risk of falling from the wheelchair and confirmed some modifications to her current wheelchair could be made to decrease her fall risk. DOR #303 verified no modification had been made to Resident #13's wheelchair to decrease the fall risk. Interview on 03/04/25 at 4:22 P.M. with MDS Coordinator (MDSC) #301 confirmed Resident #13's care plan was not updated until 03/03/25 with an intervention to frequently monitor and boost Resident #13 in the wheelchair as needed. 2. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of dementia, and muscle wasting and atrophy. Review of the quarterly MDS assessment dated [DATE] revealed Resident #12 had impaired cognition, was dependent for transfers and used a wheelchair for ambulation. Further review revealed Resident #12 had a fall with a non-major injury since the previous assessment. Review of the progress notes in Resident #12's electronic medical record dated 12/14/24 through 12/16/24 revealed no documentation of a fall. Review of the neurological assessments completed in Resident #12's electronic medical record revealed one was completed on 12/14/25 at 1:35 P.M. and the next one was not completed until 12/15/24. Review of a 72 Hour QShift Follow Up Assessment, dated 12/15/24 at 2:01 A.M. revealed Resident #12 was assessed by a nurse for vital signs, range of motion, level of consciousness and pain. Further review revealed a skin assessment section, including an area to document a skin tear, abrasion, bruise, laceration, or other, with no areas marked. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an IDT progress note dated 12/17/24 revealed the team met to develop a fall intervention for Resident #12's fall on 12/14/24. Interview on 03/03/25 at approximately 12:30 P.M. with the DON and concurrent review of the facility's fall investigations revealed the DON was unable to provide copies of the facility's confidential risk management documentation of falls. The DON proceeded to verbally read the document regarding the circumstances of Resident #12's fall and confirmed the resident had a fall on 12/14/24 at 7:20 A.M. The DON stated Resident #12 was found lying on the floor next to the bed. The DON stated range of motion and vitals were obtained and notifications to the family and provider were completed. The DON did not identify any injuries sustained by Resident #12. Interview on 03/04/25 at 11:55 A.M. with MDSC #301 revealed the quarterly MDS assessment dated [DATE], which indicated Resident #12 had a fall with injuries, reflected an abrasion and bruising to Resident #12's left eyebrow as a result of the fall on 12/14/24. Continued interview with MDSC #301, and concurrent review of Resident #12's Treatment Administration Record (TAR) dated December 2024, revealed a physician order was initiated on 12/17/24 to monitor bruising and abrasion to the left eye until healed, twice daily. Further review revealed an additional physician order initiated 12/17/24 to monitor bump on the back of the head until healed, twice daily. Further review of Resident #12's TAR for December 2024 revealed the order to monitor the bruising and abrasion and the order to monitor the bump on the back of the head were documented with an x for the morning shift on 12/17/24. The administration boxes were blank for the evening shift on 12/17/24, both shifts on 12/18/24, 12/19/24, 12/20/24, 12/21/24, and 12/22/24 and the morning shift on 12/23/24. A check mark and staff initials were documented in the evening box on 12/23/24. A follow up interview on 03/04/25 at 2:50 P.M. with MDSC #301 confirmed a check mark on a TAR indicated the treatment/assessment was completed. MDS Coordinator #301 confirmed the boxes from the evening of 12/17/24 through the morning of 12/23/24 were blank for the order to monitor Resident #12's bruising and abrasion at left eye, and were blank for the order to monitor Resident #12's bump on the back of her head. MDS Coordinator #301 was unable to verify whether the monitoring was completed. Continued interview on 03/04/25, beginning at 2:50 P.M., with the DON confirmed the first two neurological checks completed for Resident #12, in the electronic medical record, were dated 12/14/24 and 12/15/24. The DON further confirmed the facility's policy regarding neurological assessments stated an assessed was completed every 15 minutes x 4, then every 30 minutes x 2, then every hour x 2, then every 4 hours x 5, and lastly every 8 hours x 24 hours. Further interview and concurrent review of the neurological assessment completed 12/14/24 confirmed it was not completed until 1:35 P.M. (approximately six hours after the resident's fall at 7:20 A.M.). Review of the facility policy titled, Neurological Assessment, revised 03/19/21, revealed a neurological assessment should be initiated following any obvious head trauma. Further review revealed an assessment should be completed every 15 minutes x 4, every 30 minutes x 2, every hour x 2, every 4 hours x 5, and every 8 hours x 24 hours and were to be completed for a minimum of 48 hours. This deficiency represents non-compliance investigated under Complaint Number OH00162615.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on medical record review, staff interview and review of the facility incident report, the facility failed to ensure fall incidents were documented in the resident medical record. This affected one (#12) of three residents reviewed for falls. The facility census was 46. Findings include: Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of dementia, and muscle wasting and atrophy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/13/25, revealed Resident #12 had impaired condition, was dependent for transfers and used a wheelchair for ambulation. Further review revealed Resident #12 had a fall with a non-major injury since the previous assessment. Review of the progress notes in Resident #12's electronic medical record dated 12/14/24 through 12/16/24 revealed no documentation of a fall. Review of the neurological assessments completed in Resident #12's electronic medical record revealed one was completed on 12/14/25 at 1:35 P.M. and the next one was completed on 12/15/24. Review of a 72 Hour QShift Follow Up Assessment, dated 12/15/24 at 2:01 A.M. revealed Resident #12 was assessed by a nurse for vital signs, range of motion, level of consciousness and pain. Review of an interdisciplinary treatment team (IDT) progress note dated 12/17/24 revealed the team met to develop a fall intervention for Resident #12's fall on 12/14/24. Interview on 03/03/25 at approximately 12:30 P.M. with the Director of Nursing (DON) and concurrent review of the facility's fall investigation revealed the DON was unable to provide copies of the facility's confidential risk management documentation of falls. The DON proceeded to verbally read the document, which confirmed Resident #12 had a fall on 12/14/25 at 7:20 A.M. The DON stated Resident #12 was found lying on the floor next to the bed. The DON stated range of motion and vitals were obtained and notifications to the family and provider were completed. The DON did not identify any injuries sustained by Resident #12. Interview on 03/04/25 at 11:55 A.M. with MDS Coordinator (MDSC) #301 revealed the quarterly MDS assessment dated [DATE] indicating Resident #12 had a fall with injuries reflected an abrasion and bruising to the resident's left eyebrow as a result of the fall on 12/14/25. A follow-up interview on 03/04/25 at 12:14 P.M. with MDSC #301 and the DON confirmed the nursing progress notes in Resident #12's electronic medical record did not include documentation of the events surrounding the resident's fall on 12/14/24. The DON revealed the fall was documented in the facility's confidential risk management system. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25, beginning at 2:50 P.M., with the DON revealed she was able to share the facility's confidential risk management documentation regarding Resident #12's unwitnessed fall on 12/14/24 at 7:20 A.M. and provided an incident report. Review of the facility's incident report dated 12/14/24 at 7:20 A.M. and locked on 12/17/24 at 8:23 A.M. revealed details regarding Resident #12's fall, including the circumstances of the fall and the injuries she sustained. Further review of the document revealed the statement Privileged and Confidential - Not part of the Medical Record - Do not Copy. This was an incidental finding during the complaint survey completed 03/04/25.		