

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 06/18/2025
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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, review of the Cubex (computerized medication dispensing machine, provided and maintained by the contracted pharmacy, for frequently used medications to be available for immediate use) inventory sheet, facility policy review and interviews with staff, pharmacy and family, the facility failed to implement a timely, effective and adequate pain management plan for Resident #143 following the resident's admission to the facility. This affected one (#143) of one resident reviewed for pain management. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #143 revealed an admission date of 06/05/25 at 1:10 P.M. and a discharge date of 06/05/25 at 10:20 P.M. Resident #143 had diagnoses including low back pain, chronic pain syndrome, intervertebral disc degeneration-thoracic region, lumbosacral intervertebral disc degeneration, radiculopathy-lumbar region, spinal stenosis-lumbosacral region, spinal stenosis-lumbar region, spondylosis, and intervertebral disc displacement-lumbosacral region.</p> <p>Review of the admission assessment dated [DATE] revealed Resident #143 was alert and oriented to person, place, time, and situation.</p> <p>Review of the admission orders dated 06/05/25 revealed Resident #143 was prescribed gabapentin (used to treat pain) 200 milligram (mg) three times daily at 8:00 A.M., 12:00 P.M. and 8:00 P.M., Percocet (narcotic medication used to treat pain) 5-325 mg, one tablet every eight hours as needed (PRN) for pain, quetiapine fumarate (antipsychotic medication used off label to treat chronic pain) 25 mg at bedtime for chronic pain, and Tylenol 500 mg, two tablets every six hours as needed for pain.</p> <p>Review of the baseline care plan dated 06/05/25 revealed Resident #143 had pain due to an unstable spine. Interventions included pain medication as prescribed and to administer pain medication 30 minutes prior to any treatments.</p> <p>Review of a nursing progress note dated 06/05/25 at 9:15 P.M. revealed Resident #143 was administered two extra strength Tylenol per order for resident complaints of back pain. Further review revealed the resident was Requesting narcotic, writer informed resident that medication not in yet from pharmacy that should be in later this evening. Resident sitting on bed stating she needed Percocet but decided to take the Tylenol at this time.</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record (MAR) for June 2025 revealed on 06/05/25 at 9:15 P.M., Resident #143 was administered acetaminophen (Tylenol) 500 mg, two tablets, for pain rated at a 10 on a zero to 10 scale. Further review revealed, upon reassessment, the Tylenol was not effective in managing Resident #143's pain. Additionally, the MAR revealed no doses of Percocet were administered, per resident request, and neither the quetiapine fumarate or gabapentin were administered, as physician ordered on this date.</p> <p>Review of a nursing progress note dated 06/05/25 at 10:03 P.M. revealed Registered Nurse (RN) #655 was in the hallway at the medication cart and heard Resident #143 on speaker phone in her room and further heard the resident state, I need help. RN #655 entered the room and the resident was still having a conversation with the person on the speaker phone, which was lying on the opposite side of the bed from the resident, who was sitting upright on her bottom on the floor. Resident #143 was asked why she was on the floor and stated, I don't know, I fell. EMS arrived and stated the resident's son called 911 to have her sent to the ER. EMS helped the resident onto the stretcher. At 10:20 P.M., the resident was transported to the ER per stretcher with EMS.</p> <p>Review of emergency room (ER) documentation dated 06/05/25 revealed Resident #143 arrived at the ER at 10:43 P.M. for complaints of diffuse pain. The resident stated she had been experiencing pain since being discharged from the hospital earlier that day and she was unable to receive any narcotic medications at the skilled nursing facility. Additionally, Resident #143 reported she received two doses of Tylenol while in the skilled nursing facility. Further review revealed that Resident #143 was administered morphine sulfate by way of intramuscular (IM) injection. A re-assessment was performed and Resident #143 was resting comfortably with a reported improvement in pain.</p> <p>Review of the Cubex machine inventory list revealed Percocet 5-325 mg, quetiapine fumarate 25 mg, and gabapentin 100 mg were on the inventory sheet as available medications in the facility's Cubex machine.</p> <p>Interview on 06/17/25 at 7:54 A.M. with Pharmacist #681 verified, Percocet 5-325 mg, quetiapine fumarate 25 mg, and gabapentin 100 mg were medications available in the facility's Cubex machine and were available for administration to Resident #143 following the resident's admission. Pharmacist #681 further stated the process for obtaining medication out of the Cubex machine for resident administration was for the facility to fax the orders to the pharmacy and then for pharmacy staff to enter the orders in the system. Pharmacist #681 revealed Resident #143's orders were received by the pharmacy on 06/05/25 at 2:27 P.M. and were entered into the system by the pharmacy staff on 06/05/25 at 5:50 P.M. Pharmacist #681 stated if a resident needed medication immediately, the facility nurse could call the pharmacy, and medications would be reviewed and processed immediately for administration from the Cubex machine. Pharmacist #681 further stated the process for getting a narcotic pain medication out of the Cubex machine required the facility nursing staff to call the pharmacy for an authorization number to pull the medication. Pharmacist #681 stated the pharmacy was staffed with their regular staff until midnight on weekdays and an on-call pharmacist was available after midnight to provide authorizations, as needed. Pharmacist #681 revealed there were no calls received on 06/05/25 for an authorization for Resident #143's medications to be pulled from the Cubex for administration.</p> <p>Interview on 06/17/25 at 4:55 P.M. with the Director of Nursing (DON) and Administrator verified pain medications were not administered as prescribed for Resident #143 and further confirmed the pain medications, Percocet, gabapentin, and quetiapine fumarate, were medications available in the Cubex for administration.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/17/25 at 5:29 P.M. with Registered Nurse (RN) #655 revealed the facility's Cubex machine contained medications that could be administered for residents who were newly admitted or had new physician orders (prior to pharmacy delivery). RN #655 confirmed she worked with Resident #143 on 06/05/25 and further verified she had access to the Cubex machine and was aware of the process to access medications from the Cubex for administration. RN #655 stated she did not recall accessing the Cubex to obtain Resident #143's pain medications or calling the pharmacy for authorization on 06/05/25. RN #655 stated she administered what she had available, which was Tylenol, for Resident #143's pain. During the interview, RN #655 was unable to recall any specific information related to Resident #143 or her pain on 06/05/25.</p> <p>A telephone interview on 06/18/25 at 11:55 A.M. with Resident #143's family member revealed on 06/05/25, the resident called her from the facility because she was in pain. Resident #143's family member stated she did not reside in the area and reached out to another family member, who was closer, to check on the resident. The local family member called 911 for the resident.</p> <p>Review of the facility policy titled, Pain Management, revised December 2021, revealed each resident would be assessed upon identification of pain. Further review revealed after consultation with the physician and resident, medication and dosage schedules would be established based on characteristics of the resident's pain.</p> <p>Review of the facility policy titled, Medication Administration Policy, revised July 2021, revealed medications would be administered to residents/elders as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166633.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, pharmacy staff interview, medical record review, closed medical record review, and review of the Cubex (computerized medication dispensing machine containing frequently used medications for immediate access for new admissions and/or new physician orders) machine inventory sheets, the facility failed to ensure medication doses were verified prior to administration and further failed to ensure available medications were administered per physician order. This affected two residents (#28 and #143) reviewed for medication administration. The facility census was 45.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #28 revealed an admission date of 11/01/24 with a diagnosis of depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had mild cognitive impairment.</p> <p>Review of the current physician orders revealed Resident #28 was prescribed Wellbutrin XL (medication used to treat depression) oral tablet extended release (ER) 24 hour 150 milligrams (mg), one tablet in the morning.</p> <p>Observation on 06/17/25 at 7:23 A.M. of medication pass revealed Registered Nurse (RN) #637 pulled the medication packet for Resident #28 labeled bupropion ER XL (generic for Wellbutrin XL). Further observation revealed the medication packet did not have the dosage of the bupropion ER XL on the label. Continued observation revealed RN #637 opened the package labeled bupropion ER XL and placed the pill in the medication cup for Resident #28, along with the rest of the resident's morning medications. Concurrent interview with RN #637 confirmed the dosage of the bupropion ER XL was not on the packaging label and further stated, I know it's the right medication; I know it by the pill. Continued observation revealed RN #637 took the medication cup of pills, that included the unknown dosage of bupropion ER XL, to Resident #28 and administered the medications to the resident. Observation revealed that at no time did RN #637 verify the bupropion ER XL she removed from the package and administered to Resident #28 was the appropriate dosage ordered by the physician.</p> <p>Interview on 06/17/25 at 7:42 A.M. with Lead Order Entry Clerk (LOEC) #680, with the facility's contracted pharmacy, stated when a medication label did not include the dosage, facility staff would be expected to compare the description of the pill on the package and the medication number stamp to the actual pill on hand with the stamped medication number on the pill and/or the administering nurse could call the pharmacy to verify the medication to ensure the correct medication was administered. The facility nurse would be expected to notify the pharmacy of the mislabeled medication packaging to rectify the package label.</p> <p>2. Review of the closed medical record for Resident #143 revealed an admission date of 06/05/25 at 1:10 P.M. and a discharge date of 06/05/25 at 10:20 P.M. Resident #143 had diagnoses including low back pain, chronic pain syndrome, intervertebral disc degeneration-thoracic region, lumbosacral intervertebral disc degeneration, radiculopathy-lumbar region, spinal stenosis-lumbosacral region, spinal stenosis-lumbar region, spondylosis, and intervertebral disc displacement-lumbosacral region.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission assessment dated [DATE] revealed Resident #143 was alert and oriented to person, place, time, and situation.</p> <p>Review of the admission orders dated 06/05/25 revealed Resident #143 was prescribed Percocet (narcotic medication used to treat pain) 5-325 mg, one tablet every eight hours as needed (PRN) for pain, Tylenol 500 mg, two tablets every six hours as needed for pain, and gabapentin (used to treat pain) 200 mg three times daily at 8:00 A.M., 12:00 P.M. and 8:00 P.M., .</p> <p>Review of the baseline care plan dated 06/05/25 revealed Resident #143 had pain due to an unstable spine. Interventions included pain medication as prescribed and to administer pain medication 30 minutes prior to any treatments.</p> <p>Review of a nursing progress note dated 06/05/25 at 9:15 P.M. revealed Resident #143 was administered two extra strength Tylenol per order for (resident) complaints of back pain. Further review revealed the resident was Requesting narcotic, writer informed resident that medication not in yet from pharmacy that should be in later this evening. Resident sitting on bed stating she needed Percocet but decided to take the Tylenol at this time.</p> <p>Review of the Medication Administration Record (MAR) for June 2025 revealed on 06/05/25 at 9:15 P.M., Resident #143 was administered acetaminophen (Tylenol) 500 mg, two tablets, for pain rated at a 10 on a zero to 10 scale. Further review revealed, upon reassessment, the Tylenol was not effective in managing Resident #143's pain. Additionally, the MAR revealed no doses of Percocet were administered, per resident request, and the 8:00 P.M. dose of gabapentin was not administered, per physician order.</p> <p>Review of the Cubex machine inventory list revealed Percocet 5-325 mg and gabapentin 100 mg were on the inventory sheet as available medications in the facility's Cubex machine.</p> <p>Interview on 06/17/25 at 7:54 A.M. with Pharmacist #681 verified, Percocet 5-325 mg and gabapentin 100 mg were available in the facility's Cubex machine and available for administration to Resident #143 following the resident's admission. Pharmacist #681 further stated the process for obtaining medication out of the Cubex machine for resident administration was for the facility to fax the orders to the pharmacy and then for pharmacy staff to enter the orders in the system. Pharmacist #681 revealed Resident #143's orders were received by the pharmacy on 06/05/25 at 2:27 P.M. and were entered into the system by the pharmacy staff on 06/05/25 at 5:50 P.M. Pharmacist #681 stated if a resident needed medication immediately, the facility nurse could call the pharmacy, and medications would be reviewed and processed immediately for administration from the Cubex machine. Pharmacist #681 further stated the process for getting a narcotic pain medication out of the Cubex machine required the facility nursing staff to call the pharmacy for an authorization number to pull the medication. Pharmacist #681 stated the pharmacy was staffed with their regular staff until midnight on weekdays and an on-call pharmacist was available after midnight to provide authorizations, as needed. Pharmacist #681 revealed there were no calls received on 06/05/25 for an authorization for Resident #143's Percocet or gabapentin to be pulled from the Cubex for administration.</p> <p>Interview on 06/17/25 at 4:55 P.M. with the Director of Nursing (DON) and Administrator verified Percocet and gabapentin were not administered as prescribed for Resident #143 and further confirmed Percocet and gabapentin were available in the Cubex for administration.</p> <p>(continued on next page)</p>		

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