

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365953	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Otterbein St Marys Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 11230 State Route 364 St Marys, OH 45885	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, observation, and review of facility policy, the facility failed to ensure pressure ulcer treatments were completed as ordered. This affected one (#4) of three residents reviewed for skin alterations. The census was 49. Findings include: Review of Resident #4's medical record revealed an admission date of 08/18/25. Diagnoses listed included vitamin D deficiency, atherosclerotic heart disease, neuromuscular dysfunction of bladder, and spinal stenosis. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact and had no pressure ulcers. Review of a nursing note dated 06/17/26 at 3:50 P.M. revealed the physician was in to see Resident #4. New order for betadine to the right heel and Medihoney (wound treatment gel) and bordered gauze to coccyx. Review of physician orders revealed an order dated 06/17/26 for coccyx apply Medihoney and cover with bordered gauze and right heel apply betadine every dayshift for wound healing. The order was discontinued on 06/19/26. Review of wound physician notes dated 06/17/26 revealed Resident #4 had an unstageable deep-tissue injury to the left heel with intact skin that measured 3 centimeters (cm) x 2.5 cm. Treatment plan was betadine once daily and as needed. Review of wound nurse practitioner notes dated 06/19/26 revealed Resident #4 had an unstageable deep-tissue injury to the left heel with intact skin that measured 2.8 cm x 2.5 cm. Dry, brown/black hard eschar was noted. Will paint with betadine daily, leave open to air. No erythema or drainage noted. Appears stable. Review of the medication administration record (MAR) revealed betadine was not documented as being applied to Resident #4's right heel from 06/19/26 to 06/24/26. There was no current order in place. Further review of the medical record revealed Resident #4's wound to the right heel did not worsen due to no treatments being provided. Interview with the Director of Nursing (DON) on 06/24/26 at 7:15 A.M. confirmed treatment to (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's right heel was stopped on 06/19/26 and not restarted as ordered by the wound nurse practitioner. The treatment order for the coccyx was changed and since that was a combined order, the right heel treatment was mistakenly discontinued too. There was no documentation of the right heel being treated from 06/19/26 until 06/24/26. The DON confirmed the wound physician improperly documented a left heel wound on 06/17/26. Observation of Resident #4's wound care on 06/25/26 at 9:50 A.M. revealed a wound to the right heel with eschar in place.		

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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** Based on record review, observation, staff interview, and policy review, the facility failed to assess a resident timely after a fall. The affected one (Resident #34) out of five residents reviewed for accidents. The facility census was 49. Review of Resident #34's medical record revealed an admission date of 10/03/25 with diagnoses of Parkinson's disease with dyskinesia, with fluctuations, primary osteoarthritis, psychotic disorder with delusions, dementia with agitation, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed Resident #34 had moderate cognitive impairment, required partial assistance with ambulation, and resident did not have any falls prior to assessment. Review of the Care Plan, dated 10/04/25 revealed Resident #34 was at risk for falls related to decreased mobility, deep brain stimulator, Parkinson's disease, and resident will at times placed self safely on the floor to find my belongings. Interventions included of mat placed on floor beside bed, keep Dycem placed to seat of recliner to prevent sliding, keep remote for his lift chair in its holder to reduce his risk for playing with the remote, anticipate and meet resident needs, educate about safety reminders and what to do if a fall occurs, ensure appropriate footwear is worn when ambulating or mobilizing in wheelchair, and ensure call light/pendant is within reach and encourage to use it for assistance as needed. Review of the Event Note dated 06/22/26 at 2:42 P.M. revealed on 06/22/26 at 10:30 A.M. per CNA when she walked in Resident #34's room, the resident was sitting in front of the recliner and it appeared that he slid out of chair with no injuries noted. Review of the Nurses Note dated 06/22/26 at 10:30 A.M. revealed Resident #34 was found on the floor. Staff assisted resident up. Vital signs and neuro checks started. No noted injury. Moves extremities normally. Denied hitting head. Denied pain/discomfort. Will continue to monitor. Observation on 06/22/26 at 10:03 A.M. revealed Housekeeper #202 tell Certified Nursing Assistant (CNA) #185 Resident #34 was on the floor face down. CNA #185 went into Resident #34's room and assisted the resident into the bedside chair. Interview on 06/22/26 at 10:22 A.M. with CNA #185 confirmed she told Licensed Practical Nurse (LPN) #225 Resident #34 was on the floor and CNA #185 assisted the resident back to bedside chair from a sitting position. Interview also confirmed she did not see any visible injuries. Observation on 06/22/26 at 10:23 A.M. revealed Resident #34 was still not assessed by a nurse after the fall. Interview on 06/22/26 at 10:23 A.M. with LPN #225 confirmed she did not assess Resident #34 because the resident was care planned to be on the floor. When asked at what point staff consider Resident #34 had a fall, LPN #225 stated, she didn't know, she would have to ask the Director of Nursing (DON) for that answer. Interview on 06/22/26 at 10:27 A.M. the DON confirmed Resident #34 is care planned to put himself on the floor if witnessed, but if not witnessed then the facility staff is to follow the fall protocol. Interview on 06/22/26 at 10:29 A.M. with LPN #225 and DON confirmed when Resident #34 was on the floor unwitnessed, it was to be treated as a fall. Observation on 06/22/26 at 10:37 A.M. LPN #225 was assessing Resident #34. Interview on 06/25/26 at 2:16 P.M. with the DON confirmed the charting on Resident #34 did not mention resident was found face down on 06/22/26 at 10:03 A.M. when Housekeeper #202 observed Resident #34 on the floor and reported to CNA #185 he was on the floor face down. Interview confirmed the DON had not interviewed Housekeeper #185 yet, even though the Interdisciplinary Team (IDT) note had already been completed saying resident was found sitting up beside his chair. Interview on 06/25/26 at 2:19 P.M. with Housekeeper #202 confirmed on 06/22/26 at 10:03 A.M. Resident #34 was on the floor face down and she reported to CNA #185 the resident was on the floor (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	face down. Review of the Falls Management policy dated 12/02/25 revealed in the event a fall should occur, the nurse will complete a physical assessment completed for injury, and immediate care will be provided as needed. Following the immediate assessment the physician and representative will be notified.		

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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** Based on medical record review and staff interview, the facility failed to ensure a resident's urinary catheter tubing and collection bag was changed as ordered. Additionally, the facility also failed to provide timely incontinence care to a resident. This affected two (#4 and #5) of three residents reviewed for incontinence care. The census was 49. Findings include: 1. Review of Resident #4's medical record revealed an admission date of 08/18/25. Diagnoses listed included vitamin D deficiency, atherosclerotic heart disease, neuromuscular dysfunction of bladder, and spinal stenosis. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact and had an indwelling urinary catheter. Review of physician orders revealed an order dated 08/18/25 to change urinary catheter bag and tubing as needed for catheter change, when visibly soiled or damaged, and every night shift every seven days for maintenance. Review of the treatment administration record (TAR) revealed no documentation of Resident #4's urinary catheter bag or tubing being changed on the scheduled days of 06/09/26 and 06/17/26. The TAR was blank on those days. The last documented day of the urinary and catheter bag being changed was 06/02/26. The next day documented of it being changed was 06/23/26. Interview with the Director of Nursing (DON) on 06/25/2026 at 7:40 A.M. confirmed no documentation of Resident #4 catheter bag and tubing being changed on 06/09/26 and 06/17/26, indicating it had not been completed. 2. Review of the medical record for Resident #5 revealed an admission date of 05/28/23. The resident had diagnoses which included acute transverse myelitis in demyelinating disease of the central nervous system, bacteremia, neuromuscular dysfunction of the bladder, type 2 diabetes, local infection of the skin and subcutaneous tissue, psoriasis and depression. The resident remained in the facility. Review of the quarterly MDS assessment dated [DATE] revealed Resident #5 had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. Resident #5 was dependent upon staff with toileting hygiene and was documented as always incontinent of stool. Review of the care plan revealed a focus for bowel incontinence with interventions including to change and assist with toileting as needed and to provide pericare after each incontinence episode. Observation of pericare on 06/25/26 at 9:58 A.M. with Certified Nursing Assistant (CNA) #173 for (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident#5 revealed CNA #173 had supplies prepared on the bedside table and clear trash bags on the floor beside Resident #5's bed. CNA #173 washed his hands, put on gloves and pulled the curtain around the bed for privacy. CNA #173 removed the tape from the incontinence product to expose the catheter. CNA #173 cleansed the periaarea around the catheter with soap and water, rinsed and patted the area dry. The catheter tubing was then cleansed with soap and water, rinsed and patted dry. Resident #5 was observed to be incontinent of stool during care. CNA #173 informed Resident #5 he would come back with the nurse after she had finished her medication pass so she could put the Zinc Ointment (skin protectant) on him. Resident #5 looked at this surveyor and said hurry up and wait. CNA #173 then applied a clean incontinence product (leaving the soiled incontinence product in place beneath him) over Resident #5's groin area and covered him the a sheet. Resident #5 then asked CNA #173 if he changed the incontinence product. CNA #173 explained he put a clean product on the front of him and would return with the nurse and change the soiled product after her medication pass. CNA #173 then tied the soiled linen bag and took off his gloves and gown and placed them in the second trash bag. CNA #173 then went into the bathroom to wash his hands. When he was done, a request was made for him to go into the hallway by this surveyor. During the interview, CNA #173 revealed he had not been in to check Resident #5 for incontinence until the time of the observation. CNA #173 stated he was informed the last incontinence rounding was around 4:00 A.M. or 4:30 A.M. CNA #173 explained he did not provide incontinence care, because the nurse would need to put medication on Resident #5's coccyx. CNA #173 acknowledged incontinence care could be provided since he was aware the Resident #5 was sitting in excrement and the nurse could apply medication later. Interview on 06/25/26 at 11:12 A.M. the Director of Nursing (DON) stated the facility followed [NAME] procedures for incontinence care and provided a written copy of the instruction. A second interview at 2:27 P.M. the DON acknowledged it would be the expectation incontinence care would be provided in a timely manner. Review of the [NAME] documentation titled, Incontinence management, fecal, long-term care, reviewed 12/15/25 documented if a residents incontinence brief or pad becomes soiled, remove it. Clean the perineal area with a skin cleanser after each incontinence episode and apply skin protectant cream.		

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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 staff interviews, resident interviews, and record review, the facility to follow Bilevel Positive Airway Pressure (BiPAP) orders as prescribed. This affected one Resident (#16) of three reviewed. The facility census was 49. Findings include: Review of the medical record for Resident #16 revealed an admission date of 06/03/26. The resident had diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), acute on chronic respiratory failure, Congestive Heart Failure (CHF) and localized edema. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #16 was cognitively intact and he required supervision with transfers, bed mobility, set up with eating, and moderate assistance with toileting hygiene. Review of physician orders revealed an order to apply BiPAP machine with Inspiratory Positive Airway Pressure (IPAP) of ten centimeters of water (cm H2O) and Expiratory Positive Airway Pressure (EPAP) of five cmH2O, and respirations of 13 and 35 percent (%) Fractured of Inspired Oxygen (FiO2) with three Liters Per Minute (LPM) oxygen bleed in every night shift and as needed for between meals. Review of the June Medication Administration Record (MAR) revealed a nine was documented on 06/06/26, 06/13/26, 01/15/26, 06/18/26, 06/19/26 and 06/22/26. Further review of the chart codes revealed a nine was other/see progress notes. Review of the progress notes did not reveal any documentation correlating with the Medication Administration on 06/06/26, 06/13/26, 01/15/26, 06/18/26, 06/19/26 or 06/22/26. Interview on 06/22/26 at 11:43 A.M. with Resident #16 stated the staff had not applied the BiPAP machine since his admission. He explained they had informed him they needed a piece to hook the oxygen into it. Observation at the time of the interview did not reveal oxygen tubing to be present. Interview on 06/25/26 at 8:02 A.M. with Registered Nurse (RN) #263 revealed she worked the night shift on 06/06/26, 06/13/26, 01/15/26, 06/18/26, 06/19/26 or 06/22/26. She verified she entered a nine on the corresponding dates on the MAR explaining the connector to hook the oxygen to the BiPAP was not available until 06/23/26. Review of the facility policy, Medication Administration Procedure dated 11/21/17 documented Medications are administered in accordance with the written orders of the attending physician.		

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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** Based on staff interview and record review, the facility failed to follow medication parameters during medication administration which resulted in significant medication errors. This affected one Resident (#16) of three reviewed for medication administration. The facility census was 49. Findings include: Review of the medical record for Resident #16 revealed an admission date of 06/03/26. The resident had diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), acute on chronic respiratory failure, Congestive Heart Failure (CHF) and localized edema. The resident remained in the facility. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had intact cognition and the resident required supervision with transfers, bed mobility, set up with eating, and moderate assistance with toileting hygiene. Review of the care plan revealed a focus for diuretic therapy related to hypertension with interventions including to monitor for the adverse effects of diuretic therapy of dizziness, postural hypotension, and fatigue. Review of physician orders revealed an order for Metoprolol Succinate Extended-Release tablet (blood pressure medication) 25 milligram (mg), give half a tablet one time a day and hold for a systolic Blood Pressure (SBP) of less than 110 millimeters of mercury (mmHg) and a Diastolic Blood Pressure (DBP) of less than 60 mmHg with an order date of 06/10/26. A second order was for Torsemide (diuretic) 20 mg tablet every other day with parameters to hold for a SBP of less than 110 mmHg and a DBP of less than 60 mmHg with an order date of 06/10/26. Review of the daily blood pressures revealed blood pressures were outside of parameters on 06/13/26 the blood pressure was 105 (systolic) mmHg over (/) 58 (Diastolic) mmHg, on 06/06/25 blood pressure was 92/46 mmHg, on 06/16/26 blood pressure was 92/46 mmHg, on 06/17/26 blood pressure was 104/50 mmHg, on 06/18/26 blood pressure was 94/50 mmHg, on 06/19/26 blood pressure was 100/52 mmHg, 06/21/26 blood pressure was 101/70 mmHg, and on 06/23/26 blood pressure was 98/50 mmHg. Record review of the June Medication Administration Record revealed a half of a 25 mg tablet of Metoprolol Succinate was documented as administered on 06/13/26, 06/06/25, 06/16/26, 06/17/26, 18/26, 06/19/26, 06/21/26 and on 06/23/26. Record review of the June Medication Administration Record revealed 20 mg tablet of Torsemide was documented as given on 06/13/26, 06/17/26, 06/19/26 and 06/21/26. Interview on 06/24/26 at 1:52 P.M. with the Director of Nursing (DON) verified Metoprolol Succinate and Torsemide blood pressure medications were administered outside of parameters. Review of the facility policy, Medication Administration Procedure, dated 11/21/17 documented medications are administered in accordance with the written orders of the attending physician.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Centers for Disease Control (CDC) Guidelines, and staff interviews, the facility failed to ensure infection procedures were followed during incontinence care. This affected one resident (#5) of two reviewed for incontinence care and infection control. The facility census was 49. Findings include: Review of the medical record for Resident #5 revealed an admission date of 05/28/23. The resident had diagnoses which included acute transverse myelitis in demyelinating disease of the central nervous system, bacteremia, neuromuscular dysfunction of the bladder, type 2 DM, local infection of the skin and subcutaneous tissue, psoriasis and depression. The resident remained in the facility. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had a Brief Interview Mental Status (BIMS) score of 14 indicating intact cognition. Resident #5 was dependent upon staff with toileting hygiene and was documented as always incontinent of stool. Review of the care plan revealed a focus for bowel incontinence with interventions which included but were not limited to change and assist with toileting as needed and to provide pericare after each incontinence episode. Observation on 06/25/26 at 10:21 A.M. of incontinence care with Certified Nursing Assistant (CNA) #173 assisted by CNA #183 for Resident #5 revealed Resident #5 was assisted onto his right side and cleansed of stool by CNA #173. Resident #5 was then assisted onto his back. CNA #173 and CNA #183 both used toilet paper to cleanse stool from the groin area. CNA #183 was observed to have excrement on both gloves. CNA #183 was then observed to look at her gloves and then use toilet paper to remove stool from her gloves. CNA #183 continued to assist with cleansing Resident #5 without changing gloves. CNA #183 then pulled the clean incontinence product out from under Resident #5. After Resident #5 was encouraged to return to his back, CNA #183 then used her soiled gloves to readjust the catheter tubing over Resident #5's leg. Interview on 06/25/26 at 10:35 A.M. immediately following incontinence care, CNA #183 verified she had wiped stool from both of her gloves using toilet paper and did not change them until after incontinence care was completed and the repositioning of the catheter tubing had been completed. Review of CDC guidelines revealed instruction was to change gloves and clean hands if gloves become soiled.		