STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366242	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Sunset Village	9640 Sylvania-Metamora Road Sylvania, OH 43560

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. (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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy the facility failed to monitor a residents wound and implement wound interventions. This affected one (#30) of three residents reviewed for wounds. The facility census was 42.Findings Include:Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included hemiplegia affecting right dominant side, type two diabetes mellitus with foot ulcer, non-pressure chronic ulcer of other part of unspecified foot with unspecified severity, neuromuscular dysfunction of bladder, diabetes mellitus due to underlying condition with foot ulcer, atherosclerotic heart disease of native coronary artery without angina pectoris, malignant neoplasm of head (face and neck), and cerebral infarction. Review of the Minimum Data Set (MDS) assessment, dated 08/01/25, revealed the resident was severely cognitively impaired. The resident was dependent for showering, personal hygiene, lower body dressing, and footwear. Resident #30 had a diabetic foot ulcer. Review of the care plan, dated 04/25/24, revealed Resident #30 was care planned for activities of daily living self-care and mobility performance due to diabetes with foot ulcer, Alzheimer's, and hemiplegia. Interventions included to apply boots bilaterally in the morning and remove at night and float legs with pillows. Review of the care plan, revised on 12/29/24, revealed Resident #30 had a history of non-pressure ulcers to feet due to diabetes, lack of sensation to affected area, and vascular insufficiency. Interventions include to ensure appropriate protective devices are applied to affected areas, monitor wound size, depth, margins and document progress in wound healing on an ongoing basis, and treatment documentation include measurement of each area of skin breakdown (width, length, depth, type of tissue and exudate and any other notable changes or observations). Review of physician orders, dated 01/10/25, revealed an order to apply [NAME] green boots bilaterally in the morning and remove at night and float legs with pillows two times a day left plantar foot wound. Review of weekly skin assessment tools, dated the last 12 weeks, revealed on 07/28/25, 08/13/25, and 09/03/25 Resident #30's left foot diabetic ulcer was measured but did not include characteristics or descriptions of the wound bed. Weekly skin assessments dated 06/20/25, 06/24/25, 07/02/25, 07/09/25, 08/05/25, 08/27/25, and 08/21/25, revealed no documented measurements of Resident #30's left foot diabetic ulcer. Review of hospice visit notes, dated the last year, revealed the hospice agency provided the facility with brief written notes after each visit with Resident #30. The notes do not include detailed weekly wound documentation.Interview on 09/04/25 at approximately 8:20 A.M. with the Director of Nursing (DON) verified she had obtained weekly wound record reports from the hospice agency. DON verified she had not previous reviewed the wound reports and if she had would have addressed it as the notes identified Resident #30 diabetic foot ulcer as a stage two pressure ulcer. DON verified the facility skin assessments did not include weekly wound measures and wound characteristics. Interview via telephone on 09/04/25 at 9:39 A.M. with Hospice Registered Nurse (RN) #300 verified the hospice agency completed Resident #30's weekly wound assessments and overall the wound has had improvement. Observation on 09/04/25 at 11:10 A.M. of Resident #30 revealed the resident was in bed with no boots applied. Interview on 09/04/25 at 11:23 A.M. with Certified Nursing Assistant (CNA) #170 verified Resident #30's bilateral boots were not applied and the resident's heels and legs were directly on the air mattress. CNA #170 stated she was told the boots were applied at night and taken off in the morning and would not have applied them during her shift. Review of the policy, Skin Care Management Procedure, revised 12/09/22, verified with each dressing change or at lease weekly at a minimum documentation should include the date observed, location and staging, size, depth, the presence, location, and the extent of any undermining or tunneling/sinus tract, exudates (if present the type, color, odor, and approximate amount), pain (if present the nature and frequency), wound bed (color and type of tissue/character including evidence of healing or necrosis and percentage of tissue, and description of wound edges and surrounding tissue. This deficiency represents non-compliance investigated under Complaint Number 2593574.

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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 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** Based on medical record review, observation, and staff interview, the facility failed to ensure accurate resident medical records. This affected one (#30) of three residents reviewed for accurate medical records. The facility census was 42. Findings Include:Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included hemiplegia affecting right dominant side, type two diabetes mellitus with foot ulcer, non-pressure chronic ulcer of other part of unspecified foot with unspecified severity, neuromuscular dysfunction of bladder, diabetes mellitus due to underlying condition with foot ulcer, atherosclerotic heart disease of native coronary artery without angina pectoris, malignant neoplasm of head (face and neck), and cerebral infarction. Review of the Minimum Data Set (MDS) assessment, dated 08/01/25, revealed the resident was severely cognitively impaired. The resident was dependent for showering, personal hygiene, lower body dressing, and footwear. Resident #30 had a diabetic foot ulcer. Review of the care plan, dated 04/25/24, revealed Resident #30 was care planned for activities of daily living self-care and mobility performance due to diabetes with foot ulcer, Alzheimer's, and hemiplegia. Interventions included to apply boots bilaterally in the morning and remove at night and float legs with pillows. Review of physician orders, dated 01/10/25, revealed an order to apply [NAME] green boots bilaterally in the morning and remove at night and float legs with pillows two times a day left plantar foot wound. Review of the Medication Administration Review (MAR), dated September 2025, revealed Resident #30's [NAME] green boots were applied in the morning. Observation on 09/04/25 at 11:10 A.M. of Resident #30 revealed the resident was in bed with no boots applied. Interview on 09/04/25 at 11:17 A.M. with Licensed Practical Nurse (LPN) #178 verified Resident #30's bilateral boots were not applied and had been marked in the MAR as applied. Interview on 09/04/25 at 11:23 A.M. with Certified Nursing Assistant (CNA) #170 verified Resident #30's bilateral boots were not applied and the resident's heels and legs were directly on the air mattress. CNA #170 stated she was told the boots were applied at night and taken off in the morning and would not have applied them during her shift.