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	02/19/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, medical record review, staff interview, and review of facility medication administration policies, the facility failed to ensure medications were administered in accordance with physician orders resulting in a medication error rate greater that five percent (%). A total of two medication errors were observed out of 28 opportunities for a medication error rate of 7.14%. This affected two (#4 and #5) of three residents reviewed for medication administration in a facility census of 43.Findings include:1. Observation on 02/18/26 at 8:50 A.M. noted Registered Nurse (RN) #300 preparing Resident #4's medications for administration. RN #300 obtained medications from the medication cart and placed them into a clear medication cup. One medication included metoprolol succinate extended release (ER) tablet 25 milligrams (mg). At 8:58 A.M. RN #300 proceeded to Resident #4's room and provided the medications whole with water which Resident #4 consumed.Review of Resident #4's medical record noted a physician order dated 09/11/25 for the administration of metoprolol succinate ER tablet 25 mg one tablet by mouth once daily for hypertension related to hypertensive chronic kidney disease with instructions to hold for systolic blood pressure less than 100 millimeters of mercury (mmHg) or heart rate less than 60 beats per minute.On 02/18/26 at 9:20 A.M. interview with RN #300 verified no vital signs were obtained prior to administering Resident #4's metoprolol succinate ER.2. Observation on 02/18/26 at 9:13 A.M. noted RN #300 obtaining Resident #5's medications from the medication cart. RN #300 removed medications from the cart and placed them in a clear medication cup. One medication included an antibiotic cephalexin oral capsule 500 mg. RN #300 placed applesauce into the medication cup with the medications and proceeded to Resident #5 room. At 9:19 A.M., RN #300 provided the medications to Resident #5.Review of Resident #5's medical record revealed a physician order dated 02/10/26 for the administration of cephalexin oral capsule 500 mg one capsule by mouth four times a day for cellulitis for 10 Days. Further review revealed the prescribed administration times were designated for 8:00 A.M., 12:00 P.M., 16:00 (4:00 P.M.), and 20:00 (8:00 P.M.). On 02/18/26 at 9:20 A.M. interview with RN #300 verified Resident #5's cephalexin was administered outside of the physician prescribed timeframe.Review of the facility medication administration policy, revised 11/09/21, revealed medications are administered in accordance with written orders or the attending physician or physician extender. Medications are administered within one hour before or one hour after scheduled time.Review of the facility liberal medication administration policy, dated 11/02/22, revealed medications that must be administered with equally spaced hours of administration and are time sensitive, such as every four hours include antibiotic medications. Medication administration that require equal spaced administration times include four times daily are scheduled for administration at 8:00 A.M., 12:00 P.M., 16:00 (4:00 P.M.), and 20:00 (8:00 P.M.).This deficiency represents non-compliance investigated under Complaint Number 2732128.

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

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	02/19/2026

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 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 observation, medical record review, staff interview, and review of facility medication administration policies, the facility failed to ensure medications were administered in accordance with physician orders resulting in significant medication errors. This affected three (#1, #4, and #5) of four residents reviewed for administration of medications in a facility census of 43.Findings include:1. Review of the medical record revealed Resident #1 admitted to the facility on [DATE] with diagnoses including cerebrovascular disease, type II diabetes mellitus, major depressive disorder, chronic peripheral venous insufficiency, epilepsy, hypertension, chronic pain, cortical blindness, myalgia, urge incontinence, transient ischemic attack, anxiety disorder, and morbid obesity. Review of Resident #1's most current Minimum Data Set assessment dated [DATE] revealed the resident was assessed with moderate difficulty hearing, severely impaired vision, and moderately impaired cognition. The resident received antidepressant, diuretic, opioid, antiplatelet, and anticonvulsant medications, and received oxygen therapy and hospice care.Review of Resident #1's medical record revealed on 11/24/25 a physician order was implemented for the administration of the narcotic pain medication morphine sulfate (concentrate) oral solution 20 milligrams per milliliter (mg/mL) with instruction to give 0.5 mL by mouth every two hours as needed for pain/shortness of breath. Further review revealed the resident had no active physician order for the administration of the narcotic pain medication Dilaudid.Review of Resident #1's medical record revealed event documentation dated 11/25/25 at 3:48 P.M. and contained documentation as follows; 11/25/25, 0932, 11/25/25, 1400. Description: include how they were found, chain of events: Sitting up in recliner watching television. Resident Account of Event:: Resident reports pain while sitting up in chair. Description of Environmental, Physiological, and Predisposing Factors: Medication not administered by six rights of medication administration.Further review revealed a resident assessment was completed and the resident's oxygen saturation was below 90 percent (%); as needed oxygen was applied and oxygen saturation returned to above 90% on 2.5 liters (L)/nasal cannula (NC). There were no injuries and the immediate intervention to reduce the risk of this happening again included education provided to the nurse (Licensed Practical Nurse (LPN) #200) on six rights of medication administration. Notification was made to the physician and Resident #1's responsible party, hospice, and Power of attorney. Resident #1 denied discomfort, but was drowsy while resting in bed comfortably. No documentation contained in the medical record indicated the content of the incident, ongoing assessment of resident's health status, physician instructions, or reason indicating why LPN #200 was educated on six rights of medication administration. Review of Resident #1's medical record lacked additional documentation until 11/29/25 when a weekly skin observation tool was completed. No additional progress notes were contained in the medical record until 12/01/25 with no mention of a medication error. On 02/19/26 at 8:26 A.M. interview with the Director of Nursing (DON) and the Administrator, during a review of Resident #1's medical record, revealed the entry dated 11/25/25. The DON stated on 11/25/25 LPN #200 reported she administered two different doses of the pain medication Dilaudid in error to Resident #1 instead of the ordered morphine. The DON was unable to indicate the resident which the Dilaudid was prescribed. There was no information in the medical record documented the medication or dose given to Resident #1. The DON verified she did not check the amount of Dilaudid suspension level prior to LPN #200's shift or the amount left in the bottle following the incident. The DON verbalized LPN #200 drew up the medication in an oral syringe was 0.5 mL of Dilaudid. The conclusion of the DON verbal interactions with LPN #200 following the incident indicated LPN #200 did not identify the appropriate medication before administering it to Resident #1.2. Observation on 02/18/26 at 8:50 A.M. noted (continued on next page)

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	02/19/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) #300 preparing Resident #4's medications for administration. RN #300 obtained medications from the medication cart and placed them into a clear medication cup. One medication included metoprolol succinate extended release (ER) tablet 25 milligrams (mg). At 8:58 A.M. RN #300 proceeded to Resident #4's room and provided the medications whole with water which Resident #4 consumed.Review of Resident #4's medical record noted a physician order dated 09/11/25 for the administration of metoprolol succinate ER tablet 25 mg one tablet by mouth once daily for hypertension related to hypertensive chronic kidney disease with instructions to hold for systolic blood pressure less than 100 millimeters of mercury (mmHg) or heart rate less than 60 beats per minute.On 02/18/26 at 9:20 A.M. interview with RN #300 verified no vital signs were obtained prior to administering Resident #4's metoprolol succinate ER.3. Observation on 02/18/26 at 9:13 A.M. noted RN #300 obtaining Resident #5's medications from the medication cart. RN #300 removed medications from the cart and placed them in a clear medication cup. One medication included an antibiotic cephalexin oral capsule 500 mg. RN #300 placed applesauce into the medication cup with the medications and proceeded to Resident #5 room. At 9:19 A.M., RN #300 provided the medications to Resident #5.Review of Resident #5's medical record revealed a physician order dated 02/10/26 for the administration of cephalexin oral capsule 500 mg one capsule by mouth four times a day for cellulitis for 10 Days. Further review revealed the prescribed administration times were designated for 8:00 A.M., 12:00 P.M., 16:00 (4:00 P.M.), and 20:00 (8:00 P.M.). On 02/18/26 at 9:20 A.M. interview with RN #300 verified Resident #5's cephalexin was administered outside of the physician prescribed timeframe.Review of the facility medication administration policy, revised 11/09/21, revealed medications are administered in accordance with written orders or the attending physician or physician extender. Medications are administered within one hour before or one hour after scheduled time.Review of the facility liberal medication administration policy, dated 11/02/22, revealed medications that must be administered with equally spaced hours of administration and are time sensitive, such as every four hours include antibiotic medications. Medication administration that require equal spaced administration times include four times daily are scheduled for administration at 8:00 A.M., 12:00 P.M., 16:00 (4:00 P.M.), and 20:00 (8:00 P.M.).This deficiency represents non-compliance investigated under Complaint Number 2732128.

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	02/19/2026

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 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 and staff interview, the facility failed to ensure medical record documentation contained complete and accurate information to accurately represent resident experiences, response to services, and changes in condition involving a medication error. This affected one (#1) of three residents reviewed for medical record content in a facility census of 43.Findings include:Review of the medical record revealed Resident #1 admitted to the facility on [DATE] with diagnoses including cerebrovascular disease, type II diabetes mellitus, major depressive disorder, chronic peripheral venous insufficiency, epilepsy, hypertension, chronic pain, cortical blindness, myalgia, urge incontinence, transient ischemic attack, anxiety disorder, and morbid obesity. Review of Resident #1's most current Minimum Data Set assessment dated [DATE] revealed the resident was assessed with moderate difficulty hearing, severely impaired vision, and moderately impaired cognition. The resident received antidepressant, diuretic, opioid, antiplatelet, and anticonvulsant medications, and received oxygen therapy and hospice care.Review of Resident #1's medical record revealed on 11/24/25 a physician order was implemented for the administration of the narcotic pain medication morphine sulfate (concentrate) oral solution 20 milligrams per milliliter (mg/mL) with instruction to give 0.5 mL by mouth every two hours as needed for pain/shortness of breath. Further review revealed the resident had no active physician order for the administration of the narcotic pain medication Dilaudid.Review of Resident #1's medical record revealed event documentation dated 11/25/25 at 3:48 P.M. and contained documentation as follows; 11/25/25, 0932, 11/25/25, 1400. Description: include how they were found, chain of events: Sitting up in recliner watching television. Resident Account of Event:: Resident reports pain while sitting up in chair. Description of Environmental, Physiological, and Predisposing Factors: Medication not administered by six rights of medication administration.Further review revealed a resident assessment was completed and the resident's oxygen saturation was below 90 percent (%); as needed oxygen was applied and oxygen saturation returned to above 90% on 2.5 liters (L)/nasal cannula (NC). There were no injuries and the immediate intervention to reduce the risk of this happening again included education provided to the nurse (Licensed Practical Nurse (LPN) #200) on six rights of medication administration. Notification was made to the physician and Resident #1's responsible party, hospice, and Power of attorney. Resident #1 denied discomfort, but was drowsy while resting in bed comfortably. No documentation contained in the medical record indicated the content of the incident, ongoing assessment of resident's health status, physician instructions, or reason indicating why LPN #200 was educated on six rights of medication administration. Review of Resident #1's medical record lacked additional documentation until 11/29/25 when a weekly skin observation tool was completed. No additional progress notes were contained in the medical record until 12/01/25 with no mention of a medication error, ongoing assessments, or physician recommendations following the medication error. On 02/19/26 at 8:26 A.M. interview with the Director of Nursing (DON) and the Administrator, during a review of Resident #1's medical record, revealed the entry dated 11/25/25. The DON stated on 11/25/25 LPN #200 reported she administered two different doses of the pain medication Dilaudid in error to Resident #1 instead of the ordered morphine. The DON was unable to indicate the resident which the Dilaudid was prescribed. There was no information in the medical record documented the medication or dose given to Resident #1. The DON verified she did not check the amount of Dilaudid suspension level prior to LPN #200's shift or the amount left in the bottle following the incident. The DON verbalized LPN #200 drew up the medication in an oral syringe was 0.5 mL of Dilaudid. The conclusion of the DON verbal interactions with LPN #200 (continued on next page)

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	02/19/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following the incident indicated LPN #200 did not identify the appropriate medication before administering it to Resident #1. The DON confirmed there was no documentation contained in the medical record reflecting the details of the incident. On 02/19/26 at 12:05 P.M. interview with the Administrator revealed the facility did not have documented guidance or procedures to ensure accurate resident information and experiences were contained in the medical record, including pertinent information regarding medication errors.This deficiency represents an incidental finding discovered during investigation of Complaint Number 2732128.