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	10/24/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, observations, staff interview and review of facility policy, the facility failed to ensure residents were cleaned up after meals to promote dignity. This affected one resident (#33) reviewed for dignity. The facility census was 47. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE]. Diagnoses included dementia, cerebral vascular accident (CVA) (stroke) and aphasia (unable to speak). Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/31/24, revealed Resident #33 was cognitively impaired and was (staff) dependent for personal hygiene. Review of the care plan, initiated February 2024, revealed Resident #33 required total assistance for personal care and hygiene. Observation on 10/21/24 at 10:52 at A.M. revealed Resident #33 was sitting at a dining room table in her wheelchair, with her eyes closed, and no food in front of her. Resident #33 was wearing a shirt saver and had a lap blanket across her lap. Both the shirt saver and the lap blanket had food spilled on them. Continued observation revealed an unknown nursing student standing at the nurses' station, located directly in front of the breakfast table where Resident #33 was sitting with the soiled shirt saver and blanket. Further observation revealed the unknown nursing student did not provide care for Resident #33 to remove the soiled shirt saver or soiled blanket. Observation on 10/21/24 at 10:54 A.M. revealed State tested Nursing Assistant (STNA) #527 walked past Resident #33 sitting at the dining room table with food spilled on shirt saver and lap blanket and did not address the food on the shirt saver or the lap blanket. Observation on 10/21/24 at 10:55 A.M. revealed another unknown nursing student arrived to the unit, stopped at the nurses' station, spoke to the other unknown nursing student and did not address the spilled food on Resident #33's shirt saver or lap blanket. Observation on 10/21/24 at 10:55 A.M. revealed an unknown STNA arrived on the unit, went to the nursing station and did not address the spilled food on Resident #33's shirt saver or lap blanket. (continued on next page)

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	10/24/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/21/24 at 10:57 A.M. revealed STNA #527 went from a resident's room to the common area, walking past Resident #33, to wash her hands and proceeded to another resident's room. STNA #527 did not address the spilled food on Resident #33's shirt saver or the lap blanket. Resident #33 continue sitting in her wheelchair at the dining table with her eyes closed. Observation on 10/21/24 at 10:57 A.M. revealed an unknown STNA left the nurses station, walking past Resident #33, and did not address the spilled food on her shirt saver or the lap blanket. Observation on 10/21/24 at 10:59 A.M. revealed the same unknown STNA returned to the nurses' station, walking past Resident #33 to and from the nurses' station, and did not address the spilled food on the resident's shirt saver or lap blanket. Observation on 10/21/24 11:00 A.M. revealed STNA #527 walked by Resident #33 and did not address the spilled food on shirt saver or lap blanket. Resident #33 remained at the dining table in her wheelchair with her eyes closed. Observation on 10/21/24 at 11:01 A.M. revealed STNA #527 removed the shirt saver and lap blanket from Resident #33. STNA #527 moved Resident #33 from the dining table to the common area in front of the television. Interview on 10/21/24 at 11:01 A.M. with STNA #527 verified Resident #33 was sitting at the dining room table with a shirt saver and lap blanket that had food spilled on it. Interview on 10/21/24 at 11:09 A.M. with Resident #33 was unsuccessful. Concurrent observation, while next to Resident #33, revealed she had a quarter sized glob of oatmeal in her hair, food on her headband and dried food on her face and right hand. Observations on 10/21/24 at 11:38 A.M. and 12:10 P.M. revealed Resident #33 was in common area, in front of the television. Resident #33 still had the quarter sized glob of oatmeal in her hair, food on her headband and dried food on her face and right hand. Observation on 10/21/24 at 12:15 P.M. revealed STNA #527 moved Resident #33 from the common area to the dining table for lunch. Resident #33 still had the quarter sized glob of oatmeal remained in her hair, food on her headband and dried food on her face and right hand. Interview on 10/21/24 at 12:21 P.M. with Licensed Practical Nurse (LPN) #473 verified Resident #33 had a quarter sized glob of oatmeal in her hair, food on her headband and dried food on her face and right hand. Review of the facility policy titled Federal and Ohio Residents Rights and Facility Responsibilities dated October 2019, revealed a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.

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	10/24/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, observation and staff interview the facility to ensure call lights were with resident's reach. This affected one resident (#9) of one resident reviewed for call lights. The facility census was 47. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included bipolar disorder, panic disorder, anxiety and epilepsy. Review of the care plan, revised October 2024, revealed Resident #9 was care planned for assistance with activities of daily living (ADLs) and fall risk with an identified intervention of call light in reach. Observation on 10/23/24 at 8:37 A.M. revealed Resident #9 was resting in bed and the call light was laying at the bottom of the bed, near the resident's feet, and not in reach of the resident. Interview on 10/23/24 at 8:48 A.M. with State tested Nursing Assistant (STNA) #430 verified the call light was located at the foot of the bed by Resident #9's feet not in reach of the resident. STNA #430 further stated Resident #9 was able to use the call light and make her needs known. Interview on 10/23/24 at 12:09 P.M. with the Administrator revealed the facility did not have a policy for call lights.

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	10/24/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on medical record review, staff interview and review of facility policy, the facility failed to ensure the physician and responsible party were notified when medications were not administered as ordered by the physician. This affected one (#30) of one residents reviewed for notification of change of condition. The facility census was 47. Findings include: Review of Resident #30's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus, non-pressure chronic ulcer of the heel and midfoot, neuromuscular dysfunction of bladder, benign prostatic hyperplasia, seizure disorder, coronary artery disease, depression, hypertension, peripheral vascular disease, malignant neoplasm of the head, face and neck, cerebral infarction, transient cerebral ischemic attack and history of venous thrombus and embolism. Review of the Minimum Data Set (MDS) assessment, dated 07/29/24, revealed Resident #30 was moderately cognitively impaired, had impaired range of motion to one upper extremity and required substantial to maximum (staff) assistance with activities of daily living (ADLs). Review of Resident #30's physician orders revealed the following orders: Hyoscyamine Sulfate Oral Tablet Disintegrating 0.125 milligrams (mg) give one tablet by mouth at bedtime for for overactive bladder may repeat one time after four hours if symptoms reappear; Lantus SoloStar Subcutaneous Solution Pen injector (Insulin Glargine) inject 10 units subcutaneously at bedtime for diabetes mellitus type II; Apixaban Oral Tablet 5 mg give one tablet by mouth two times a day for atrial fibrillation related transient cerebral ischemic attack, unspecified venous thrombosis and embolism and history of pulmonary embolism; Humalog Kwik Pen Subcutaneous Solution Pen injector (Insulin Lispro) inject as per sliding scale: if 0 - 249 = 0 units; 250 - 300 = 2 units; 301 - 350 = 4 units; 351 - 400 = 6 units; 401 - 450 = 8 units two times a day (morning and bedtime) for diabetes mellitus type II with further instructions to call Hospice for blood glucose over 450; Namenda Oral Tablet 10 mg give one tablet by mouth two times a day for Alzheimer's disease; Tamsulosin Oral Capsule 0.4 mg give one capsule by mouth two times a day for Benign Prostatic Hypertrophy; and Buspirone Oral Tablet 5 mg by mouth three times a day for depression. Review of the Medication Administration Record (MAR) for October 2024 revealed Licensed Practical Nurse (LPN) #551 documented 8 for the bedtime administration doses of Buspirone, Tamsulosin, Namenda , Humalog insulin sliding scale and Apixaban on 10/12/24, 10/13/24, 10/16/24 and 10/21/24. Additional review of the MAR revealed 8 indicated nauseated or vomiting. Further review of the medical record revealed no evidence the physician or responsible party were notified of the missed medications. Interview on 10/22/24 at 6:25 A.M. with LPN #551 revealed Resident #30 refused the bedtime doses of medications on 10/12/24, 10/13/24, 10/16/24 and 10/21/24. LPN #551 confirmed the medications refused during the identified evenings included insulin, an anticoagulant and mood disorder medications. LPN #551 also verified the physician and family were not notified of the medication refusals. (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	10/24/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Notification of Change of Condition, revised 11/22/21, revealed the facility will immediately inform the resident; consult with the residents physician and notify the residents representative when there is a need to alter treatment significantly (example: a need to discontinue an existing form of treatment due to adverse consequences, or commence a new form of treatment).

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	10/24/2024

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 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** 47057 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure fall interventions were implemented. This affected one resident (#9) of three residents reviewed for falls. The facility census was 47. Findings include: Review of the medical record for Resident #9 revealed an admitted [DATE]. Diagnoses included osteoarthritis, dementia, anxiety and bipolar disorder. Review of the most recent quarterly Minimum Data Set (MDS) assessment revealed Resident #9 had some cognitive impairment. Review of the comprehensive fall risk assessment, dated 10/01/24, revealed Resident #9 was at risk for falls and had no falls in the past 90 days. Review of the care plan, revised October 2024, revealed Resident #9 was at risk for falls. Interventions included a fall mat. Observation on 10/21/24 at 10:23 A.M. of Resident #9 revealed she was in bed. A fall mat was leaning against the wall. Observation on 10/22/24 at 9:31 A.M. of Resident #9 revealed she was in bed. A fall mat was leaning against the wall. Interview on 10/22/24 at 10:32 A.M. with Licensed Practical Nurse (LPN) #473 revealed Resident #9 was to have a fall mat next to the bed when she was in bed. LPN #473 verified Resident #9 was in bed and the fall mat was leaning against the wall and not in place. Review of the facility policy titled Falls Management, revised December 2019, revealed the care plan will be reviewed and dated to assure it has been updated to reflect the current needs of the resident to prevent further falls.

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	10/24/2024

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. 15816 Based on observation, medical record review, staff interview and review of facility procedure, the facility failed to ensure medications were administered in a form as ordered by the physician, resulting in a medication error rate above five percent (%). This affected one (#37) of three residents observed during medication administration. A total of eight medication errors were observed out of 32 opportunities for a medication administration error rate of 25.00%. The facility census was 47. Findings include: Observation on 10/22/24 at 7:29 A.M. of medication administration revealed Licensed Practical Nurse (LPN) #550 prepared medications for Resident #37. LPN #550 obtained the following medications from the medication cart: Amlodipine five milligram (mg), half tablet; Cholecalciferol 50 micrograms (mcg) tablet; Citalopram 40 mg tablet; Famotidine 20 mg tablet; Ferrous Sulfate 325 mg tablet; Magnesium Oxide 400 mg tablet; Senna-Docusate Sodium 8.6-50 mg, two tablets; and Calcium Citrate 950/200 mg, two tablets. LPN #550 proceeded to crush the tablets and placed them in applesauce, mixing them together. The Amlodipine 5 mg half tablet was crushed separate, placed into a medication cup and mixed with with applesauce. LPN #550 proceeded into Resident #37's room, with the medications, obtained vital signs and administered the medications to the resident. Review of Resident #37's physician orders revealed the following: Amlodipine 5 mg half tablet by mouth in the morning for hypertension; Citalopram 40 mg tablet by moth one time a day for depression; Cholecalciferol 50 mcg tablet one time a day; Famotidine 20 mg tablet one time a day for Gastroesophageal reflux disease (GERD); Ferrous Sulfate 325 mg tablet one time a day for anemia; Magnesium Oxide 400 mg tablet one time a day; Senna-Docusate Sodium 8.6-50 mg two tablets two times a day for constipation; Calcium Citrate 950/200 mg two tablets three times daily for GERD. Further review of the physician orders revealed no order to crush Resident #37's medications. Interview 10/22/24 at 7:58 A.M. with LPN #550 confirmed she crushed Resident #37's medications prior to administration. LPN #550 verified there was no physician order to crush the resident's medications. Review of the facility document titled Medication Administration Procedure, revised 11/09/21, revealed medications are to be administered in accordance with written orders of the attending physician or physician extender. If safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or tube-fed. Further review revealed the need for crushing medications is indicated on the resident's orders and the Medication Administration Record (MAR) so all personnel administering medications are aware of the need and the consultant pharmacist can advise on safety issues and alternatives during medication regimen reviews. This deficiency represents non-compliance investigated under Complaint Number OH00158467.

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	10/24/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37451 Based on observation, resident interview, staff interview and review of the Resident Council meeting minutes, the facility failed to ensure residents were provided with meals at an appetizing temperature. This affected two residents (#98 of #3) of seven residents who received food from the secured memory care unit serving kitchen but did not reside on the secured unit. The facility census was 47. Findings Include: Interview on 10/21/24 at 9:58 A.M. with Resident #98 revealed the resident was alert and aware. Resident #98 revealed she ate her meals in her room and by the time her meals got to her they were cold. Resident #98 stated the food did not taste good when it was cold. Interview on 10/21/24 at 10:06 A.M. with Resident #3 revealed the resident was alert and aware. Resident #3 revealed her only concern was the food served to residents in their rooms was always cold. Observation on 10/21/24 at 11:30 A.M. revealed the lunch meal cart was delivered to the serving kitchen on the secured memory care unit. Food temperatures were taken at 11:34 A.M. and the burger temperature was 150 degree Fahrenheit (F), the soup was 166 degrees F, the pureed green beans were 151 degrees F and the mashed potatoes were 146 degrees F. Continued observation revealed the lunch plates were removed from the overhead cupboard. The plates were not heated/warmed, and there were no insulated bases or lids to help maintain food temperatures. The plate covers were clear plastic covers, which had holes in the center. Observation on 10/21/24 at 12:02 P.M. revealed Dietary Staff (DS) #342 started plating food. An uncovered cart was observed with serving trays on it. Coinciding interview with DS #342 verified the open cart was used to transport the room trays to the seven residents who resided outside of the secured memory care unit. Observation on 10/21/24 at 12:22 P.M. of the lunch meal service revealed seven meals were plated and placed on the open cart. There were only five clear plastic covers for the seven meals. The meals remained on the open cart until 12:35 P.M., when Dietary Manager (DM) #478 returned with two additional clear plastic covers. Approximately 30 minutes after the seven meals were plated, the cart was then taken for meal delivery. Interview on 10/21/24 at 12:52 P.M. with Resident #3 revealed the burger was cold and the soup was lukewarm. Resident #3 stated the burger was not even warm enough to melt the cheese and lifted the bun to show unmelted cheese on top of the burger patty. Resident #3 stated the food was almost always cold. Interview on 10/21/24 12:54 P.M. with Resident #98 revealed the burger was terrible as it was cold and the soup was lukewarm. (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	10/24/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/21/24 at 1:00 P.M. of a lunch test tray revealed food items included chicken and rice soup, mashed potatoes and pureed green beans. There were no burger patties left to test. Temperatures were taken and the mashed potatoes were 113 degrees F, the pureed green beans were 100 degrees and the soup temperature was 110. The soup was flavorful, but the temperature was lukewarm. The pureed green beans were cold and bland and the mashed potatoes were slightly warm. Coinciding interview with DS #342 verified the cool food temperatures. DS #342 stated food items cooled quickly once they were taken off the steam table. Review of the Resident Council Meeting Minutes dated 05/20/24 and 06/24/24 revealed residents had concerns for the temperatures of food, hot foods were cold and cold foods were warm.

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	10/24/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37451 Based on observation and staff interview, the facility failed to maintain a clean and sanitary serving kitchen. This had the potential to affect 18 residents (#3, #4, #5, #7, #8, #15, #16, #22, #23, #24, #26, #29, #32, #35, #36, #40, #46 and #98) who received food from the secured memory care unit serving kitchen. The facility census was 47. Findings include: Observation on 10/21/24 at 11:30 A.M. of the serving kitchen on the secured memory care unit revealed the floor was sticky and covered in food debris and splatters. There was a build-up of food debris in the corners and along the bottom of the cabinets and equipment. The floor was sticky enough in areas where a shoe became stuck and was pulled partially off. Continued observation revealed splatters and a build-up of dried food on the front of the lower cabinets and on the wall behind the kitchen sink and steam table. The juice machine had a build-up of a sticky substance behind the nozzles and along the wall next to the juice machine. Interview on 10/21/24 at 11:37 A.M. with Dietary Staff (DS) #342 verified there was build-up of food on floor, the floor was sticky, the juice machine needed to be cleaned, the cabinets had dried food residue and dried food was on the walls behind the steam table and kitchen sink. DS #342 stated she was not aware of the last time the serving kitchen had been cleaned. DS #342 stated she tried to clean the serving kitchen once a week when she worked dinner service. DS #342 could not recall the last time she worked the dinner shift and cleaned the kitchen. Observation on 10/23/24 at 10:32 A.M. of the secured memory care unit serving kitchen revealed the floors had been swept and mopped and the juice machine had been wiped down. However, dried food remained on the lower cupboards, the walls behind serving steam table, the wall next to the juice machine and the wall behind the sink.

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	10/24/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41528 Based on observation, staff interview, review of the Legionella (bacteria that can cause a severe type of pneumonia) Risk Assessment, review of facility policy and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure appropriate handling of linen to prevent contamination. In addition, the facility failed to have an appropriate Legionella water management program in place. This had the potential to affect all 47 residents of the facility. The facility census was 47. Findings include: 1. Observation on 10/21/24 at 2:41 P.M. revealed State tested Nursing Assistant (STNA) #437 carried two large stacks of linens, with one stack of linens in each arm and pressed against the top half of her body. STNA #437 walked through the locked double doors of the unit and to the linen closet. STNA #437 pressed the linens against the door and her body while entering the code to unlock the doors. Interview on 10/21/24 at 2:44 P.M. with STNA #437 verified she transported the clean linens uncovered and pressed against her body and the door. Observation on 10/22/24 at 1:49 P.M. of the laundry room washing machine area revealed no gowns were observed. Interview on 10/22/24 at 1:50 P.M. with Laundry Aide (LA) #489 verified gloves were worn when handling soiled linens but gowns were not worn to prevent possible cross-contamination. 2. Review of the facility's undated Legionella Risk Assessment revealed three of the fist four questions were answered Yes. Interview on 10/23/24 at approximately 3:15 P.M. with the Administrator revealed answering Yes to any of the first four questions on the facility's Legionella Risk Assessment indicated the facility was at high risk for Legionella. While the Administrator was identified as part of the water management team, he was uncertain of elements of the plan and referred the surveyor to Director of Environmental Services (DES) #508 for additional information related to the facility's Legionella plan. Interview on 10/23/24 at 4:32 P.M. with DES #508 revealed he was responsible for the facility's Legionella prevention plan. DES #508 stated he was not very familiar with Legionella and was not certain of the monitoring requirements. DES #508 stated an external company recently conducted a cooling tower water treatment report, temperatures of faucets and hot water heaters. DES #508 was unable to articulate control measures implemented on a routine basis, stated there was no regular monitoring of facility water temperatures and the faucets in empty rooms were not flushed to ensure no Legionella growth. (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	10/24/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Legionnaires Policy, dated 09/07/17, revealed the facility will identify and assess potential sources of Legionella bacteria, determine the correct operation of water systems and will ensure that necessary maintenance/monitoring is carried out by competent personnel. Additionally, the Quality Assurance Performance Improvement (QAPI) Committee will review the water management program elements annually and as needed, to include deciding where control measures should be applied and how to monitor them. Review of the CDC guidance titled Overview of Water Management Programs, dated 03/15/24, revealed water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Further review revealed the seven key elements of a Legionella water management program included: Establish a water management program team Describe the building water systems Identify areas where Legionella could grow and spread Decide where control measures should be applied and how to monitor them Establish ways to intervene when control limits are not met Ensure the program runs as designed and is effective Document and communicate all the activities This deficiency represents non-compliance investigated under Complaint Number OH00158467.

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	10/24/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, review of immunization records, review of electronic mail (e-mail) communication, staff interview, review of facility policy and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure residents were offered or administered pneumococcal vaccinations per CDC recommendations. This affected two (#22 and #30) of five residents reviewed for pneumococcal vaccination. The facility census was 47. Findings include: 1. Review of the medical record revealed Resident #22 was admitted on [DATE]. Diagnoses included unspecified diastolic heart failure, chronic kidney disease stage three, type two diabetes mellitus without complications and lymphedema. Review of the Minimum Data Set (MDS) assessment, dated 07/14/24, revealed the resident was cognitively intact and the pneumococcal vaccine was not up to date. Review of the immunization record revealed Resident #22 last received the pneumococcal vaccine (PCV13) on 09/15/17. Review of vaccine consent documentation, dated 05/30/23, revealed Resident #22 provided verbal consent to receive the pneumococcal vaccine PCV20. Review of the nursing progress note, dated 06/02/23, revealed Resident #22 stated she does not have to have the pneumococcal due to her doctor providing the last dose in 2017. Resident #22 refused Prevnar 20. Review of vaccine consent documentation, dated 09/28/23, revealed Resident #22 declined pneumococcal consent citing the previously received PCV13 on 09/15/17. Further review revealed no evidence Resident #22 was educated on different pneumococcal vaccinations and CDC recommendations. Interview on 10/23/24 at 1:48 P.M. with the Director of Nursing (DON) verified Resident #22 had initially agreed to the pneumococcal vaccine then declined per the progress note on. A follow-up interview on 10/23/24 at approximately 3:00 P.M. with the DON revealed Resident #22 had been under the belief that the pneumococcal vaccine was not due for ten years and now agreed to the receiving the vaccine. The DON verified the facility had no evidence Resident #22 had been educated on pneumococcal vaccinations prior to today. 2. Resident #30 admitted to the facility on [DATE] with the diagnosis including, type II diabetes mellitus, non-pressure chronic ulcer of heel and midfoot, neuromuscular dysfunction of bladder, benign prostatic hyperplasia, seizure disorder, coronary artery disease, depression, hypertension, peripheral vascular disease, malignant neoplasm of head, face and neck, cerebral infarction, transient cerebral ischemic attack, and history of venous thrombus and embolism. (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	10/24/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 07/29/24, revealed the resident was moderately cognitively impaired. Review of the immunization record revealed no evidence Resident #30 had been offered or received pneumococcal vaccination. Review of the vaccination consent form revealed Resident #30's resident representative consented to the influenza and COVID-19 vaccine; however, the pneumococcal vaccination was blank. The vaccination signature read emailed consent. Review of an electronic mail (e-mail) dated 10/02/24 revealed the facility e-mailed Resident #30's representative to inquire about the seasonal flu and the latest COVID-19 vaccines. There was no mention of the pneumococcal vaccine. Interview on 10/23/24 1:54 P.M. with the DON verified Resident #30's vaccination consent did not address pneumococcal vaccination and further verified the facility did not have record of previous vaccination and had not offered or administered a pneumococcal vaccination to Resident #30. Review of the facility policy titled Influenza and Pneumococcal Immunization, revised 06/19/19, verified each resident, upon admission, will be offered the pneumococcal immunization. The resident or their legal representative will receive education regarding the benefits and potential side effects of the immunization prior to administration. The resident or their representatives have the right to refuse the immunization. Review of the CDC guidance titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 09/17/24 and located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html, revealed the CDC recommended pneumococcal vaccination for all adults over 65. For adults over 65 who had not previously received any pneumococcal vaccine, the CDC recommended to administer PCV15, PCV20, or PCV21. If PCV15 is used, administer a dose of PPSV23 one year later, if needed. If PCV20 or PCV21 is used a dose of PPSV23 is not indicated.

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	10/24/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on observation and staff interview, the facility failed to ensure Resident #4's wheelchair was maintained in a clean and sanitary manner. In addition, the facility failed to ensure Resident #15's room was free from prevasive odors. This affected two (#4 and #15) of 12 residents reviewed for environment. The facility census was 47. Findings include: 1. Review of the medical record revealed Resident #4 was admitted on [DATE]. Diagnoses included unspecified dementia with other behavioral disturbance, major depressive disorder severe with psychotic symptoms, heart failure, hyperlipidemia, essential primary hypertension, hypothyroidism and dysphagia. Review of the Minimum Data Set (MDS) assessment, dated 07/22/24, revealed the resident was severely cognitively impaired with impairment on to both sides of the body and required the use of a wheelchair. Observation on 10/21/24 at 10:21 A.M. revealed Resident #4 in a wheelchair with a heavy amount of dirt and food crumbs on the wheelchair frame, including an intact pretzel. Observation on 10/22/24 at 11:00 A.M. revealed Resident #4 in a wheelchair with dirt and food crumbs on the wheelchair frame and on the visible area of the seat cushion. Interview on 10/22/24 at 11:01 A.M. with State tested Nursing Assistant (STNA) #506 revealed wheelchairs were cleaned by third shift staff on the resident's shower days and as needed. STNA #506 verified Resident #4's wheelchair was dirty with a thick layer of food and debris. 2. Observation on 10/21/24 at 9:54 A.M. of Resident #15's room revealed the resident's room was malodorous with an unidentified smell. Additional random observations on 10/22/24, 10/23/24 and 10/24/24 revealed Resident #15's room continued to have an unpleasant odor. Interview on 10/22/24 at 2:18 P.M. with STNA #437 revealed Resident #15's room always had a smell. Interview on 10/24/24 8:59 A.M. with the Director of Nursing (DON) verified Resident #15's room had an unpleasant odor. This deficiency represents non-compliance investigated under Complaint Number OH00158467. 47057 (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	10/24/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 10/22/24 at 10:15 A.M. revealed a chunk of breadlike substance with pink tinge and unidentifiable food crumbs on the floor underneath the table and alongside the table in the dining room. Further observation on 10/22/24 at 10:18 A.M. revealed an unknown kitchen staff sweeping the floor after breakfast and the unknown kitchen staff did not sweep under or around the table where the food was left on the floor. Interview on 10/22/24 at 10:23 A.M. with Dietary Aide (DA) #463 verified there was food on the floor under and alongside the table. DA #463 stated the food was from dinner the previous night because she did not service it during breakfast that morning.