STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366314	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein at Granville	2158 Columbus Road Granville, OH 43023

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to provide proper justification for the use of anti-psychotic medications. This affected one (Resident #7) of two residents reviewed for medication use. The census was 18.Findings Include:Resident #7 was admitted to the facility on [DATE]. Her diagnoses were Parkinson's disease, morbid obesity, hypertension, hyperlipidemia, major depressive disorder, insomnia, sleep apnea, anxiety disorder, delusional disorder, dementia, dysphagia, psychotic disorder, vitamin D deficiency, anemia, and Type II Diabetes. Review of his minimum data set (MDS) assessment, dated 03/12/26, revealed he had a mild cognitive impairment.Review of Resident #7's physician orders, dated 12/06/25, revealed he was prescribed Quetiapine (antipsychotic) 25 milligrams (mg) every morning for delusions, paranoia related to psychotic disorder with delusions due to known physiological condition. Also, he was prescribed Quetiapine 50 mg, 1.5 tablets at bed time for the same diagnosis as above on 02/10/26. Finally, he was prescribed Depakote Tablet (anticonvulsnt) 125 mg for unspecified dementia with mood disturbance, which was ordered on 02/17/26. Review of Resident #7's discontinued physician orders, revealed the following medications and diagnoses: Quetiapine 50 mg for delusions, paranoia related to psychotic disorder from 12/06/25 to 02/10/26; Quetiapine 25 mg, 0.5 tablets for the same diagnosis as above from 12/07/25 to 02/10/26; and Divalproex Sodium Tablet (Depakote) 125 mg three times daily for delusions, paranoia related to delusional disorders, dementia from 12/06/25 to 02/04/26. Review of Resident #7's psychiatry notes, dated 07/02/25, revealed there was no documentation of a past diagnosis of psychotic disorder. The chief complaint listed for this visit was for continual monitoring for depression, anxiety, and insomnia. In the psychiatric follow-up section, the notes reflected that the resident had a history of depression, anxiety, insomnia, Parkinson's disease with dementia, and recurrent urinary tract infections (UTI). There was no documentation reflecting he was diagnosed with psychotic disorder. Review of Resident #7's psychiatry notes, dated 08/13/25, revealed no diagnosis of psychotic disorder. But, the chief complaint listed for this visit was continual monitoring for depression, anxiety, insomnia, and Parkinson's disease with dementia and psychosis. Under the section that reviewed psychosis specifically, the notes reflected that he denies having hallucinations, delusions, or paranoia, but endorses frequent, extremely vivid, disturbing dreams. Review of Resident #7's behavioral logs, dated May 2025 to August 2025, revealed no behaviors for May 2025, June 2025, and July 2025. In August 2025, he had two documented behaviors, one for repeated movements and one for yelling/screaming. There were no documented behaviors leading up to the new documented diagnosis of psychotic disorder listed in August 2025. Review of Resident #7's psychiatry notes, dated 09/11/25, revealed his Melatonin (supplement sedative/hypnotic agent) dose was increased from six mg to ten mg after his last appointment on 08/27/25. Resident #7 reported during his appointment on 09/11/25 that he had better sleep with fewer vivid dreams. Interview with [NAME] President #500 on 04/28/26 at 10:55 A.M. confirmed that dementia is not a proper diagnosis for the use of Depakote, and confirmed that it was the listed diagnosis for Resident #7's use of Depakote. Interview with Director of Nursing (DON) on 04/28/26 at (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:15 P.M. confirmed there was no diagnosis of psychotic disorder for Resident #7 prior to August 2025. She confirmed there were signs and symptoms of delusions and paranoia, but there was no documentation to support he actually had the diagnosis of psychotic disorder.Review of facility Psychotropic Medication Management policy, dated 03/05/25, revealed it is the policy of the facility to ensure each resident's drug regimen is free from unnecessary psychotropic medications. When psychotropic medications are ordered, the facility will ensure a comprehensive assessment of the resident's physical, behavioral, mental, and psychosocial signs and symptoms have been completed to identify and rule out any underlying medical conditions and specific diagnosis is documented in the medical record.

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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 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 interview and record review the facility failed to ensure neurological assessments were completed after an unwitnessed fall. This affected one (Resident #6) out of one residents reviewed for falls. The facility census was 18.Findings include:Review of the medical record for Resident #6 revealed an admission date of 10/16/23 with diagnoses including history of transient ischemic attack, syncope and collapse, hypertension, dementia and atrial fibrillation.Review of the care plan dated 04/15/25 revealed the resident had a history of an actual fall with minor injury. Interventions included performing neurological checks after any falls and monitoring/reporting neurological deficits such as changes in level of consciousness, visual changes, aphasia, dizziness, weakness and restlessness.Review of the Fall Risk Screening Tool dated 10/27/25 revealed the resident was identified as being at risk for falls.Review of annual minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was severely cognitively impaired, has not had any falls and required substantial/maximal assistance with chair to bed transfers. Review of the fall report dated 12/02/25 at 7:48 P.M. revealed the resident encountered an unwitnessed fall while attempting to exit a recliner. The resident was observed with bruising to the left side of the face, bruising on the left dorsal hand, and redness to the left collarbone. Neurological checks were initiated.Review of the hospice visit note dated 12/03/25 revealed scattered bruising to the right side, left eye, left collarbone, and left upper extremity from the elbow to the knuckles. The resident was noted to be taking Plavix and Eliquis (blood thinners), placing her at higher risk for bleeding and bruising.Review of the neurological check documentation revealed completed assessments on 12/02/25 at 6:30 P.M., 6:38 P.M., and 7:18 P.M.; on 12/03/25 at 5:02 A.M., 5:03 A.M., 7:39 A.M., 11:44 A.M., 3:00 P.M., and 7:00 P.M.; on 12/04/25 at 3:21 A.M., 7:51 A.M., 5:46 P.M., and 9:46 P.M.; on 12/05/25 at 5:44 A.M. and 5:40 P.M.; and on 12/06/25 at 9:40 A.M. Interview on 04/28/26 at 2:35 P.M. with the Director of Nursing (DON) confirmed required neurological assessments were missing following Resident #6's unwitnessed fall on 12/02/25.Review of the facility's Neurological Assessment Policy dated 03/19/21 revealed assessments should be initiated following any obvious head trauma, acute change in mental status, or unwitnessed fall. The policy requires neurological assessments every 15 minutes for four assessments, then every 30 minutes for two assessments, every hour for two assessments, every four hours for five assessments, and every eight hours for 24 hours.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physicianˆordered laboratory specimens were collected. This affected one resident (Resident #5) out of one resident reviewed for laboratory services. The facility census was 18.Findings include:Review of the medical record for Resident #5 revealed an admission date of 04/19/24 with diagnoses of major depressive disorder, Type II Diabetes Mellitus, chronic kidney disease, calculus of kidney and morbid obesity due to excess calories.Review of the care plan dated 05/23/25 revealed the resident had renal insufficiency with interventions to monitor laboratory reports as ordered and report results to the physician. The care plan also revealed the resident had Diabetes Mellitus Type II with an intervention to complete laboratory tests as ordered due to the risk of complications.Review of the physician visit dated 01/14/26 revealed the resident was seen for diabetes mellitus, hypertension, and chronic kidney disease follow up. The physician documented weight loss, improved blood sugars, and a plan to collect a glycated hemoglobin (A1C) in April 2026 for diabetes management. The note also documented a slight decrease in glomerular filtration rate (GFR) and a plan to recheck the basic metabolic panel (BMP) in three months.Review of the physician order dated 01/14/26 revealed an active order to collect a BMP and A1C on 04/15/26.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and exhibited no refusals of care.Interview on 04/28/26 at 10:23 A.M. with the Director of Nursing (DON) revealed the laboratory results ordered for 04/15/26 could not be located.Review of an updated physician order dated 04/28/26 at 10:45 A.M. again identified orders for a BMP and A1C.Interview on 04/28/26 at 12:09 P.M. with the DON confirmed the laboratory results ordered for 04/15/26 were not found, and the DON reported that new laboratory specimens had been drawn and were currently in process.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to provide adequate monitoring for the long term use of antibiotics. This affected one (Resident #21) of one resident reviewed for antibiotic use. The census was 18.Findings Include: Resident #21 was admitted to the facility on [DATE]. Her diagnoses were senile degeneration of brain, adult failure to thrive, hypothyroidism, dysphagia, feeding difficulties, anemia, cognitive communication deficit, anxiety disorder, hypertension, major depressive disorder, cerebral atherosclerosis, abnormal weight loss, apraxia, polyosteoarthritis, vascular dementia, restlessness and agitation, vitamin D deficiency, Type II Diabetes, and somnolence. Review of her minimum data set (MDS) assessment, dated 01/27/26, revealed she had a severe cognitive impairment.Review of Resident #21's physician orders, dated 05/30/23, revealed she had an order for Macrodantin Oral Capsule (antibiotic) 50 milligram (mg) one time a day for urinary tract infection (UTI) prophylaxis. Review of Resident #21's medical diagnoses, dated June 2023 to April 2026, revealed no diagnoses of chronic UTIs or other urinary diagnoses to support the on-going need for a prophylactic antibiotic. Review of Resident #21's progress notes, dated May 2023 to April 2026, revealed she has not had a urinary tract infection since 05/18/23. Review of Resident #21's care conference notes, dated 02/04/26 and 10/22/25, revealed no discussion or review of her use of prophylactic antibiotics with the care team, which included Resident #21's family. Review of Resident #21's physician notes, dated 09/29/25, revealed she continues on Macrodantin 50 mg daily for for UTI prophylaxis due to history of recurrent UTIs. The note also confirmed she has not had an UTI in over a year. Review of the active medical problems section of the notes, there was no active diagnosis or problem listed regarding recurrent or chronic UTIs. Review of the Assessment and Plan section of the notes, it mentioned she had frequent UTIs but no recent UTIs. Continue Macrodantin. Finally, under the diagnoses section, there was no diagnoses of frequent/recurrent/chronic UTIs, but there was mention of long term (current) use of antibiotics. Interview with Registered Nurse (RN) #118 on 04/28/26 at 12:48 P.M. revealed the use of antibiotics long term and her frequent UTIs are discussed in care conferences with the family each time. She confirmed the last two care conferences do not have any mention of the antibiotic use or frequent/chronic UTIs. She stated they are monitoring the side effects of the medications, and if there was a change in condition, they would address it with the doctor. But, she stated they do not have any other type of monitor (lab work, periodic urology appointments, etc) to determine the effectiveness and needed use of long term use of the antibiotic. Review of facility Infection Prevention and Control Program policy, dated 11/05/21, revealed it is the facility's practice to prevent, recognize, and control, to the extent possible, the onset and spread of infection. This is accomplished by the development, implementation, and maintenance of an effective infection prevention and control program that achieves the following goals: perform surveillance and investigation that helps prevent, to the extent possible, the onset and the spread of infection.