STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366358	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein North Shore	9400 North Shore Blvd Lakeside, OH 43440

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** Based on medical record review, observation, staff interviews, and review of the manufacturer's instructions for the facility's mechanical lift, the facility failed to ensure resident safety when using the mechanical lift for transfers. This affected one (Resident #501) of two residents reviewed for the use of mechanical lifts. The facility census was 15.Findings include: Review of the medical record for Resident #501 revealed she was admitted on [DATE] with diagnoses including macular degeneration, dementia, osteoporosis, arthropathy, abnormalities of gait and mobility, and muscle weakness. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #501 was unable to speak, had severe cognitive impairment and was staff dependent for all care and transfers. Review of the care plan dated 04/14/25 revealed Resident #501 required the use of a mechanical lift with the assistance of two staff members for all transfers. Observation of Certified Nursing Assistant (CNA) #106 on 09/22/25 at 7:50 A.M. revealed she was using a mechanical lift independently to transfer Resident #501 from her bed to her wheelchair. There was no other staff present assisting with Resident #501's transfer. Interview with CNA #106 on 09/22/25 at 7:53 A. M. confirmed she was using the mechanical lift independently to transfer Resident #501 and typically used the mechanical lift independently to transfer residents. Interview with the Administrator on 09/22/25 at 8:28 A. M. revealed two staff members were required when utilizing the mechanical lift to transfer residents. Interview with the Director of Nursing on 09/22/25 at 2:10 P.M. revealed nursing staff were trained during orientation on the proper use of a mechanical lift. The training included the facility-implemented requirement of two staff members while transferring a resident with a mechanical lift. Review of the manufacturer's instructions for Maxi Move mechanical lift revealed circumstances should dictate the need for two-assist transfers and the facility, based on unique circumstances, was responsible for determining when the use of two-assist transfers was appropriate. This deficiency represents non-compliance investigated under Complaint Number 2609933.

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