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	03/27/2026

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 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** Based on review of the medical record, staff interview, and policy review, the facility failed to notify the physician and resident representative of changes in condition. This affected one (#26) of one resident reviewed for change in condition. The facility census was 19.Findings include: Review of the medical record for Resident #26 revealed an admission date of 02/13/26 and a discharge date of 02/23/26. Diagnoses included type two diabetes mellitus with hyperglycemia, chronic kidney disease, hypertension, and hypokalemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living. Review of the nursing notes dated 02/13/26 at 9:21 P.M. revealed the resident arrived from the hospital. Per the hospital report the resident had chronically elevated blood pressure with the systolic blood pressure as high as the 190's. The residents' medications were reviewed with the on-call provider. Review of the hospital discharge medication orders revealed Resident #26 had an order for lisinopril 20 milligrams (mg) by mouth daily, amlodipine 5 mg by mouth daily, atenolol 50 mg twice daily, hydralazine 25 mg three times a day, and hydrochlorothiazide 12.5 mg daily.Review of the physician orders dated 02/14/26 revealed the resident was ordered atenolol 50 mg twice daily for hypertension, hydralazine 25 mg three times daily for hypertension, amlodipine 5 mg twice daily for hypertension, hydrochlorothiazide 12.5 mg daily for hypertension and lisinopril 20 mg daily for hypertension. Review of the medication administration record (MAR) dated 02/13/26 revealed the resident was not administered the evening dose of the atenolol and the evening dose of the hydralazine.Review of the MAR dated 02/14/26 revealed the resident was not administered hydrochlorothiazide, lisinopril, and the morning doses of amlodipine, hydralazine, and atenolol. There was no documentation the physician and family were notified the medications were not administered. Review of the vital sign report revealed on 02/13/26 at 6:45 P.M. the resident's blood pressure was 165/81. On 02/14/26 at 12:31 P.M. the resident's blood pressure was 169/79. On 02/14/26 at 9:16 P.M., the resident's blood pressure was 193/99. On 02/24/26 at 11:38 P.M., the residents' blood pressure was 153/79. There was no documentation the resident's blood pressure was monitored in the morning on 02/14/26. There was no documentation the physician was notified of the resident's elevated blood pressure of 193/99 after not receiving her blood pressure medications.Review of a late-entry nurses note for 02/14/26 at 10:27 P.M. documented on 02/19/26 at 12:39 P.M. revealed the resident's blood pressure was elevated and her medication had just arrived from the pharmacy. The resident's family member was at the bedside and concerned about the resident's blood pressure. The nurse discussed sending the resident to the emergency room, but the family member chose to see if the medication would be effective within 60 minutes. The nurse planned to update the family with blood pressure results over the next two to four hours. Further review of the progress note revealed the medication was effective and updates were provided to the family throughout the shift and the family agreed no further action was needed at this time. Review of the Medication Inventory on Hand report revealed the amlodipine, atenolol, lisinopril, hydralazine, and hydrochlorothiazide were available to administer. Interview on 03/25/26 at 3:07 P.M., the Director of Nursing (DON) verified Resident (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#26's medications were not administered per physician orders. The DON revealed the nurse should have pulled the medications available on hand in the facility. The DON also revealed the nurse should have clarified which medications the resident had receiving prior to leaving the hospital. Further interview on 03/27/26 at 7:50 A.M., the DON verified the nurse should have notified the physician and family of the missed medications and elevated blood pressure. Review of the facility policy Notification of Change of Condition, revised 11/21/25, revealed the facility would notify the physician and resident representative of a change in the resident's condition. Review of the facility policy Medication Administration Procedure, revised 11/09/21, revealed medications would administered per physician orders and the physician would be notified of medications withheld. This deficiency represents non-compliance investigated under Master Complaint Number 2780772.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure nutritional supplements were provided as ordered. This affected two (#11,14) of four residents reviewed for nutrition. The facility identified 16 residents as receiving nutritional supplements. The facility census was 19.Findings include:1. Review of the medical record for Resident #11 revealed an admission on [DATE]. Diagnoses included unspecified dementia, major depressive disorder, and dysphagia. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had severe cognitive impairment. Further review of the MDS revealed Resident #11 was dependent on staff for feeding assistance. Review of the care plan dated 09/27/24 revealed Resident #11 was at risk for malnutrition related to inability to feed self. Interventions included providing feeding assistance, and staff were to feed the resident all meals and snacks. Further review of the care plan dated 07/16/20 revealed Resident #11 had an activity of daily living (ADL) self-care performance deficit related to dementia, and weakness. Interventions included feeding Resident #11 by staff or family. Resident #11 required one staff assistant to eat. Review of the physician's orders dated 04/03/25 revealed an order for a regular diet, pureed texture, mildly thick consistency. Further review of the care plan revealed an order on 08/13/25 for a health shake with meals for weight gain. Additional review of the physician's orders revealed an order on 10/23/25 for a magic cup with meals per speech therapy, alternating with bites of food. Observation on 03/27/26 at 8:20 A.M. revealed Certified Nursing Assistant (CNA) #218 feeding Resident #11 breakfast. Resident #11 had oatmeal, eggs, fruit, and thickened juice.Interview on 03/27/26 at 8:29 A.M. with CNA #218 revealed Resident #11 was given oatmeal, eggs, fruit and thickened juice for breakfast. CNA #218 confirmed that Resident #11 was to receive a magic cup but was unaware that the magic cup was to be given in between bites of food. CNA #218 was not aware that Resident #11 received a health shake with meals. Further interview with CNA #218 revealed in the kitchen there were resident diet orders and confirmed that Resident #11 was to receive a magic cup with meals, offering in between bites, and a health shake with every meal.2. Review of the medical record for Resident #14 revealed an admission on [DATE]. Diagnoses included hyperkalemia, chronic fatigue, and weakness. Review of the admission MDS dated [DATE] revealed Resident #14 had moderate cognitive impairment. Further review of the MDS revealed Resident #14 required supervision during mealtimes. Review of the care plan dated 03/08/26 revealed Resident #14 was at risk for changes to nutritional and hydration status related to hyperkalemia, acute kidney injury, and chronic kidney disease. Interventions included offer a substitute for meal intakes less than 50 percent. Further review of the care plan revealed Resident #14 received a mechanically altered diet and often refused. Diet was changed to regular diet, regular texture, with thin liquids on 03/21/26. Staff was to monitor weights weekly for one month, then monthly reporting any negative findings. Staff were to provide supplements as ordered. Additional review of the care plan revealed Resident #14 was at risk for altered nutrition status related to significant weight loss from hospital, and medical diagnoses. Interventions included nutritional supplements. Review of the physician's orders for Resident #14 revealed an order on 03/18/26 for magic cup supplement with meals. Observation on 03/27/26 at 8:15 A.M. revealed Resident #14 sitting at the dining room table eating two eggs, bacon, and toast.Interview on 03/27/26 at 8:29 A.M. with CNA #218 revealed Resident #14's diet card stated Resident #14 was to receive a magic cup with each meal. CNA #218 further confirmed Resident #14 was not offered a magic cup and that CNA #18 was not aware that Resident #14 had an order for a magic cup.Interview on 03/27/29 at 10:30 A.M. with the Administrator revealed there was not a policy on supplemental orders.This deficiency represents non-compliance investigated under Complaint Number 2780772

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents were administered medications per physician orders. This affected three (#26, #27, #13) of five residents reviewed for medication administration. The facility census was 19.Findings include:1. Review of the medical record for Resident #26 revealed an admission date of 02/13/26 and a discharge date of 02/23/26. Diagnoses included type two diabetes mellitus with hyperglycemia, chronic kidney disease, hypertension, and hypokalemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living. Review of the nursing notes dated 02/13/26 at 9:21 P.M. revealed the resident arrived from the hospital. Per the hospital report the resident had chronically elevated blood pressure with the systolic blood pressure as high as the 190's. The residents' medications were reviewed with the on-call provider. Review of the hospital discharge medication orders revealed Resident #26 had an order for lisinopril 20 milligrams (mg) by mouth daily, amlodipine 5 mg by mouth daily, atenolol 50 mg twice daily, hydralazine 25 mg three times a day, hydrochlorothiazide 12.5 mg daily, insulin aspart 100 units/ml per low dose sliding scale not specified, ondansetron 4 mg oral tablet by mouth every six hours as needed for nausea/vomiting, acetaminophen 325 mg, two tablets by mouth every four hours as needed for mild pain, potassium chloride 10 milliequivalents by mouth two times per day, pregabalin 75 mg by mouth every day, sertraline 50 mg by mouth daily, trazodone 50 mg at bedtime, fenofibrate 67 mg by mouth daily, and cholecalciferol 50,000 international units by mouth weekly. Review of the physician orders dated 02/14/26 revealed the resident was ordered atenolol 50 mg twice daily for hypertension, hydralazine 25 mg three times daily for hypertension, amlodipine 5 mg twice daily for hypertension, hydrochlorothiazide 12.5 mg daily for hypertension and lisinopril 20 mg daily for hypertension, aspirin 81 milligrams (mg) by mouth daily, insulin aspart 100 units/ml per low dose sliding scale 151--200 given two units, 201-250 give 3 units, 251-300 give 4 units, 301-350 five 5 units, 351-400 give 6 units and 401-799 7 units and call MD, subcutaneously before meals and at bedtime for type two diabetes mellitus with hyperglycemia, ondansetron 4 mg oral tablet by mouth every six hours as needed for nausea/vomiting, potassium chloride 10 milliequivalents by mouth two times per day, pregabalin 75 mg by mouth every day, sertraline 50 mg by mouth daily, trazodone 50 mg at bedtime, fenofibrate 67 mg by mouth daily, and cholecalciferol 50,000 international units by mouth weekly. Review of the medication administration record (MAR) dated 02/13/26 revealed the resident was not administered the evening doses of the amlodipine, hydralazine and trazodone. The resident's blood sugar was not monitored, and the resident was not administered the insulin. Review of the MAR dated 02/14/26 revealed the resident was not administered hydrochlorothiazide, lisinopril, and the morning doses of amlodipine and hydralazine, atenolol, fenofibrate, pantoprazole sodium 40 mg, pregabalin, and sertraline.Review of the Medication Inventory on Hand report revealed the amlodipine, atenolol, lisinopril, hydralazine, hydrochlorothiazide, sertraline, trazodone, potassium, pregabalin, and insulin aspart were available to administer. Interview on 03/25/26 at 3:07 P.M., the Director of Nursing (DON) verified the resident's medications were not administered per physician orders. The DON revealed the nurse should have pulled the medications available on hand in the facility. The DON also revealed the nurse should have clarified which medications the resident had receiving prior to leaving the hospital. 2. Review of the medical record for Resident #27 revealed an admission date of 03/18/26. Diagnoses included Parkinson's disease with dyskinesia, hypertension, atrial fibrillation, and abnormalities of gait and mobility.Review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the hospital medication orders revealed the resident had orders for carbidopa-levodopa 25/100 mg three times per day.Review of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders dated 03/18/26 revealed an order for carbidopa-levodopa 25/100 mg three times per day for convulsions. Review of the MAR dated 03/18/26 revealed the resident had not been administered the evening dose and bedtime dose of the carbidopa-levodopa. Further review of the MAR revealed the resident had not been administered the bedtime dose of carbidopa-levodopa on 03/19/26. Review of the Medication Inventory on Hand report revealed the carbidopa-levodopa was available for administration. Review of the nursing notes dated 03/18/26 and 03/19/26 revealed no documentation the resident had refused the medication.Interview on 03/26/26 at 3:23 P.M., the DON verified Resident #27's medication was not administered per physician orders, and the medication was available in the facility. 3. Review of the medical record for Resident #13 revealed an admission date of 03/10/26. Diagnoses included acute systolic heart failure, acute pulmonary edema, cardiomegaly, and hypertension.Review of the admission MDS assessment dated [DATE] revealed Resident #13 had intact cognition. Review of the hospital discharge medication orders revealed an order for carvedilol 6.25 mg, one tablet two times per day.Review of the physician order dated 03/10/26 revealed an order for carvedilol 6.25 mg two times a day for hypertension. Hold for systolic blood pressure less than 100 and hold if pulse was less than 60 beats per minute. Review of a nursing note dated 03/10/26 at 2:48 P.M. revealed the resident had arrived at the facility. Review of the vital sign record dated 03/10/26 at 8:20 P.M. revealed the residents' blood pressure was 116/59 with a heart rate of 84 beats per minute. Review of the MAR dated 03/10/26 revealed the evening dose of the carvedilol was not administered.Review of the nursing notes dated 03/10/26 revealed no documentation the resident had refused the medication. Review of the Medication Inventory on Hand report revealed the facility had carvedilol available for administration. Interview on 03/26/26 at 3:23 P.M., the DON verified Resident #13's medication was not administered per physician orders, and the medications were available in the facility. Review of the facility policy Medication Administration Procedure, revised 11/09/21, revealed medications were administered in accordance with written orders of the attending physician or physician extender. Review of the facility policy MedBank System Policies and Procedures, dated 10/23/25 revealed the on hand medication supply would be used for the first dose use and other situation where medication was not readily available from the pharmacy until the next scheduled delivery. This deficiency represents non-compliance investigated under Master Complaint Number 2780772 and Complaint Number 2720892.

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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 review of the medical record, staff interview, and policy review, the facility failed to ensure residents were free of significant medications errors. This affected three (#26, #27, #13) of five residents reviewed for medication administration. The facility census was 19.Findings include:1. Review of the medical record for Resident #26 revealed an admission date of 02/13/26 and a discharge date of 02/23/26. Diagnoses included type two diabetes mellitus with hyperglycemia, chronic kidney disease, hypertension, and hypokalemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living. Review of the nursing notes dated 02/13/26 at 9:21 P.M. revealed the resident arrived from the hospital. Per the hospital report the resident had chronically elevated blood pressure with the systolic blood pressure as high as the 190's. The residents' medications were reviewed with the on-call provider. Review of the hospital discharge medication orders revealed Resident #26 had an order for lisinopril 20 milligrams (mg) by mouth daily, amlodipine 5 mg by mouth daily, atenolol 50 mg twice daily, hydralazine 25 mg three times a day, and hydrochlorothiazide 12.5 mg daily.Review of the physician orders dated 02/14/26 revealed the resident was ordered atenolol 50 mg twice daily for hypertension, hydralazine 25 mg three times daily for hypertension, amlodipine 5 mg twice daily for hypertension, hydrochlorothiazide 12.5 mg daily for hypertension and lisinopril 20 mg daily for hypertension. Review of the medication administration record (MAR) dated 02/13/26 revealed the resident was not administered the evening dose of the atenolol and the evening dose of the hydralazine.Review of the MAR dated 02/14/26 revealed the resident was not administered hydrochlorothiazide, lisinopril, and the morning doses of amlodipine, hydralazine, and atenolol.Review of the vital sign report revealed on 02/13/26 at 6:45 P.M. the resident's blood pressure was 165/81. On 02/14/26 at 12:31 P.M. the resident's blood pressure was 169/79. On 02/14/26 at 9:16 P.M., the resident's blood pressure was 193/99. On 02/24/26 at 11:38 P.M., the residents' blood pressure was 153/79. Review of a late-entry nurses note for 02/14/26 at 10:27 P.M. documented on 02/19/26 at 12:39 P.M. revealed the resident's blood pressure was elevated and her medication had just arrived from the pharmacy. The resident's family member was at the bedside and concerned about the resident's blood pressure. The nurse discussed sending the resident to the emergency room, but the family member chose to see if the medication would be effective within 60 minutes. The nurse planned to update the family with blood pressure results over the next two to four hours. Further review of the progress note revealed the medication was effective and updates were provided to the family throughout the shift and the family agreed no further action was needed at this time.Review of the Medication Inventory on Hand report revealed the amlodipine, atenolol, lisinopril, hydralazine, and hydrochlorothiazide were available to administer. Interview on 03/25/26 at 3:07 P.M., the Director of Nursing (DON) verified the resident's medications were not administered per physician orders. The DON revealed the nurse should have pulled the medications available on hand in the facility. The DON also revealed the nurse should have clarified which medications the resident had receiving prior to leaving the hospital. 2. Review of the medical record for Resident #27 revealed an admission date of 03/18/26. Diagnoses included Parkinson's disease with dyskinesia, hypertension, atrial fibrillation, and abnormalities of gait and mobility.Review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the hospital medication orders revealed the resident had orders for carbidopa-levodopa 25/100 mg three times per day.Review of the physician orders dated 03/18/26 revealed an order for carbidopa-levodopa 25/100 mg three times per day for convulsions. Review of the MAR dated 03/18/26 revealed the resident had not been administered the evening dose and bedtime dose of the carbidopa-levodopa. Further review of the MAR revealed the resident had not been administered the bedtime dose of carbidopa-levodopa on 03/19/26. Review of the Medication Inventory on Hand report (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the carbidopa-levodopa was available for administration. Review of the nursing notes dated 03/18/26 and 03/19/26 revealed no documentation the resident had refused the medication.Interview on 03/26/26 at 3:23 P.M., the DON verified Resident #27's medication was not administered per physician orders, and the medication was available in the facility. 3. Review of the medical record for Resident #13 revealed an admission date of 03/10/26. Diagnoses included acute systolic heart failure, acute pulmonary edema, cardiomegaly, and hypertension.Review of the admission MDS assessment dated [DATE] revealed Resident #13 had intact cognition. Review of the hospital discharge medication orders revealed an order for carvedilol 6.25 mg, one tablet two times per day.Review of the physician order dated 03/10/26 revealed an order for carvedilol 6.25 mg two times a day for hypertension. Hold for systolic blood pressure less than 100 and hold if pulse was less than 60 beats per minute. Review of a nursing note dated 03/10/26 at 2:48 P.M. revealed the resident had arrived at the facility. Review of the vital sign record dated 03/10/26 at 8:20 P.M. revealed the residents' blood pressure was 116/59 with a heart rate of 84 beats per minute. Review of the MAR dated 03/10/26 revealed the evening dose of the carvedilol was not administered.Review of the nursing notes dated 03/10/26 revealed no documentation the resident had refused the medication. Review of the Medication Inventory on Hand report revealed the facility had carvedilol available for administration. Interview on 03/26/26 at 3:23 P.M., the DON verified Resident #13's medication was not administered per physician orders, and the medications were available in the facility. Review of the facility policy Medication Administration Procedure, revised 11/09/21, revealed medications were administered in accordance with written orders of the attending physician or physician extender. Review of the facility policy MedBank System Policies and Procedures, dated 10/23/25 revealed the on hand medication supply would be used for the first dose use and other situation where medication was not readily available from the pharmacy until the next scheduled delivery. This deficiency represents non-compliance investigated under Master Complaint Number 2780772 and Complaint Number 2720892.