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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the nurse and staff report sheet, staff interview, and review of the facility policy the facility failed to ensure correct advanced directives were in the medical chart and on the nurse and staff report sheet. This affected one (Resident #7) of one resident reviewed for advanced directives. The facility census was 19.Findings include:Review of the medical record for Resident #7 revealed an admission on [DATE]. Diagnoses included unspecified dementia, hypothyroidism, and major depressive disorder.Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #7 had impaired cognition. Further review of the MDS revealed Resident #7 required supervision or touching assistance with activities of daily living (ADL). Review of the care plan dated 08/20/25 revealed Resident #7 had a code status of Do Not Resuscitate Comfort Care (DNRCC). Interventions included reviewing Resident #7's overall goals for care and importance of comfort and quality of life regardless of the advance directive. Review of the Electronic Medical Chart (EMR) for Resident #7 revealed an order dated 09/11/25 for DNRCC.Review of the nurse and Certified Nursing Assistant (CNA) report sheet revealed Resident #7's code status was Do Not Resuscitate Comfort Care Arrest (DNRCCA).Interview on 03/25/26 at 8:10 A.M. with CNA #360 confirmed on the CNA report sheet Resident #7 had a code status of Do Not Resuscitate Comfort Care - Arrest (DNRCCA). CNA #360 was unsure what the code status meant and further stated if a resident were to be found not breathing, the CNAs are instructed to call the nurse. Interview on 03/25/26 at 9:00 A.M. with Director of Nursing (DON) confirmed that the CNA report sheet had Resident #7 as a DNRCCA and further confirmed Resident #7 was a DNRCC. Review of the facility policy titled Advanced Directives Policy dated 03/19/25 revealed on admission, the facility will determine whether the resident has executed an Advance Directive. The facility will record in the medical record, and any person designated will be notified.

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

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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 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 #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 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, interview, and policy review, the facility failed to ensure skin breakdown was timely identified and reported. Additionally, the facility failed to ensure weekly wound evaluations and weekly skin assessments were completed. This affected one (#4) of one resident reviewed for pressure ulcers. The facility identified three residents with pressure ulcers. The facility census was 19.Findings include:Review of the medical record for Resident #4 revealed an admission date of 03/27/25. Diagnoses included Alzheimer's disease, osteoarthritis, hypertension, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was at risk for skin breakdown and had a stage three pressure ulcer. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. The resident was dependent on staff for toileting and required substantial/maximal assistance for bed mobility and transfers. Review of a physician order dated 10/04/25 revealed the resident was admitted to hospice services. Review of a skin risk assessment completed 10/17/25 revealed the resident was at moderate risk for skin breakdown. Review of the medical record revealed the nurses had not completed weekly skin assessments from 10/12/25 through 11/06/25.Review of a physician wound progress note dated 10/24/25 revealed the resident had a stage two pressure ulcer (partial-thickness skin loss with exposed dermis) of the left buttock measuring 0.9 centimeters (cm) in length, one cm in width, and 0.1 cm in depth with moderate serosanguinous drainage. Review of a physician wound progress note dated 10/31/25 revealed the resident's wound evaluation was rescheduled as the resident was asleep in the recliner and nursing requested to reschedule as the resident had not slept in two days. Further review of the medical record revealed no wound follow up wound evaluation was completed from 10/25/25 through 11/06/25.Review of body audit shower sheets dated 10/31/25 and 11/05/25 revealed no documentation of new skin breakdown for the resident.Review of a physician wound note dated 11/07/26 revealed the pressure ulcer to the left buttock had resolved. The resident was found with a new stage three pressure ulcer (full thickness loss of skin, in which subcutaneous fat may be visible and granulation tissue present) to the sacrum measuring two cm in length, 2.5 cm in width, 0.1 cm in depth with moderate serous exudate with no signs of infection. The wound was noted as present for greater than five days. A wound treatment was ordered.Review of the plan of care revised 11/07/25 revealed the resident had a stage three pressure ulcer to the sacrum. Interventions included administering treatments as ordered, assist and reposition frequently with rounding and as needed, complete weekly skin screen, nutritional supplements as ordered, pressure reduction chair cushion and low air loss mattress to the bed.Interview on 03/26/26 at 10:40 A.M., Certified Nursing Assistant (CNA) #222 revealed skin changes should be marked on the body audit form and reported to the nurse. Interview on 03/26/26 at 11:38 A.M., the Director of Nursing (DON) verified the facility had not reattempted to complete a weekly wound evaluation after rescheduling with the wound physician. The DON also verified that the nursing staff had not completed a weekly skin assessment to identify new skin breakdown. The DON revealed the wound should have been discovered during incontinence care and reported. The DON revealed at the time that the resident had another buttock wound, and the nursing assistants may have thought it was the same wound, so it was not reported.Interview on 03/26/26 at 2:14 P.M., Wound Physician (WP) #700 revealed on 11/07/26 the resident was identified with a new stage three pressure ulcer to the coccyx. WP #700 revealed the resident was on hospice and underweight. WP #700 revealed the depth of the wound was minimal and would not have been a stage three in a person of average weight, however, the resident was thin and the minimal depth was into the subcutaneous tissue requiring the wound to be categorized as a stage three pressure ulcer. WP #700 revealed the pressure ulcer to the resident's left buttock was noted as healed during the same visit. WP #700 revealed the resident had been spending more time in the recliner to offload (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure on the buttocks and this could be how the coccyx pressure area developed. WP #700 revealed the documentation noting the wound duration as greater than five days was her educated guess as the wound was not present during the last wound evaluation. Review of the facility policy Skin Assessment Policy, revised 11/17/22, revealed the nurse would complete a thorough head to toe skin assessment of the resident upon admission, weekly, with significant changes and as needed. The CNAs would observe skin during bathing and personal care and report skin abnormalities to the nurse. Review of the facility policy Skin Care Management Procedure, revised 12/09/22, revealed weekly skin assessments would be completed and documented in the medical record to identify new or potential areas of concern or the absence of any areas. Further review of the policy revealed a weekly wound evaluation would be completed and documented. The physician would be notified of all skin areas of concern and consulted for treatment orders.

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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)

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy the facility failed to ensure proper personal protective equipment (PPE) was worn during care for a resident on enhanced barrier precautions (EBP). This affected one (Resident #18) resident reviewed for EBP. The facility identified four residents on EBP precautions. The census was 19.Findings include:Review of the medical record for Resident #18 revealed an admission on [DATE]. Diagnoses included Alzheimer's Disease, unspecified protein-calorie malnutrition, and occlusion and stenosis of unspecified carotid artery. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #18 had impaired cognition. Further review of the MDS revealed Resident #18 had a pressure ulcer dressing. Review of the care plan dated 02/18/26 revealed Resident #18 had an actual unstable wound to the coccyx. Resident #18 was at risk for further skin breakdown related to impaired mobility and incontinence. Interventions included turning and repositioning and weekly skin screening of Resident #18's body. Review of the care plan dated 12/07/25 revealed no care plan for Enhanced Barrier Precautions (EBP). Review of the physician's orders for Resident #18 revealed no orders for EBP. Observation on 03/25/26 at 1:14 P.M. revealed Resident #18 had a sign on the bedroom door stating EBP precautions. Staff were to wear down and gloves for high contact resident care. Observation on 03/26/25 at 8:13 A.M. of Certified Nursing Assistant (CNA) #218 and CNA #121 providing incontinence care revealed both CNA #218 and CNA #121 did not have on personal protective equipment (PPE). Interview on 03/26/25 at 8:24 A.M. with CNA #218 and CNA #121 confirmed Resident #18 was on EBP and were not wearing PPE. Interview on 03/26/25 at 10:00 A.M. with the Administrator confirmed Resident #18 was on EBP and further confirmed there were no orders in Resident #18's medical chart for EBP precautions. Review of the facility policy titled Isolation Precautions Process, dated 03/26/25 revealed Enhanced Barrier Precautions will be utilized for residents with any of the following during their entire stay: wounds. Elements of Enhanced Barrier Precautions include gloves and gowns should be worn during high contact resident care including providing hygiene, dressing, and wound care.