

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Monclova		STREET ADDRESS, CITY, STATE, ZIP CODE 5069 Otterbein Way Monclova, OH 43542	

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 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. (continued on next page)

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 ensure newly identified wounds were timely assessed and measured, and failed to ensure proper treatment timely implemented. This affected one (#20) of three residents reviewed for pressure ulcers. The facility census was 55. Findings include: Review of the medical record revealed Resident #20 was admitted on [DATE]. Diagnoses included spastic diplegic cerebral palsy, chronic kidney disease stage III, chronic respiratory failure with hypoxia, essential hypertension, mixed hyperlipidemia, hyperglycemia, and hypertensive chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 06/25/25, revealed Resident #20 was severely cognitively impaired and was at risk of pressure ulcers. Review of the care plan, updated 09/23/25, revealed Resident #20 had actual impaired skin integrity due to bilateral stage two pressure wounds (partial-thickness skin loss with exposed dermis) and was at potential risk for skin breakdown due to incontinence, weakness, and impaired mobility. Review of Resident #20's physician orders, dated 09/04/24, revealed an order to apply barrier cream two times a day for skin protection as needed. Review of nursing progress notes dated 09/06/25 revealed Resident #20 had a small open sore on the right buttock. The physician was notified via the communication book. Review of the weekly skin observation tool, dated 09/06/25, revealed Resident #20 had a small open sore on the right buttock. Further review revealed there was no assessment of the wound, no measurements, and no description of the wound documented. Review of nursing progress notes dated 09/12/25 revealed Resident #20 had two open sores on the bilateral upper buttocks and an order was placed for barrier cream twice a day and as needed. Review of the weekly skin observation tool dated 09/12/25 revealed Resident #20 had an open sore on bilateral upper buttocks. The wounds were described as small open sores to the upper bilateral buttocks with no further description of wound, assessment, or measurements included. Review of a wound physician evaluation and management summary dated 09/18/25 revealed Resident #20 had a stage two pressure ulcer on the left buttock measuring 1.0 centimeters (cm) long by (x) 0.5 cm wide x 0.1 cm deep. Resident #20 also had a stage two pressure wound to the right buttock measuring 0.4 cm long x 0.5 cm wide x 0.1 cm deep. Review of a physician order dated 09/18/25 revealed an order to apply triad hydrophilic wound dressing external paste to Resident #20's buttocks topically two times a day for a stage two pressure wound. Review of the wound physician evaluation and management summary dated 09/25/25 revealed Resident #20 had a stage two pressure ulcer on the left buttock measuring 0.5 cm long x 0.3 cm wide x 0.1 cm deep. The wound healing progress was described as improved with a decreased surface area. The stage two wound of the right buttock was resolved. Interview on 09/26/25 at approximately 11:00 A.M. with the Director of Nursing (DON) verified there was no description or wound measurements completed of Resident #20's wounds. Interview on 09/26/25 at 1:28 P.M. with the DON verified the physician should have been called on 09/06/25 when a new open area was found. Review of a policy titled, Skin Care Management, revised 11/17/22, revealed the facility will implement, monitor, and modify if needed strategies to attain or maintain intact skin, prevent complications, promptly identify, and manage complications. This deficiency represents non-compliance investigated under Master Complaint Number 2611062.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and policy review, the facility failed to wear appropriate personal protective equipment for residents on enhanced barrier precautions and failed to maintain proper infection control measures related to hand hygiene during wound care. This affected one (#16) of three residents reviewed for wounds. The facility census was 55. Findings include: Review of Resident #16's medical record revealed an admission date of 10/02/20. Diagnoses included hemiplegia and hemiparesis following a cerebrovascular accident, epilepsy, and cellulitis of the scrotum. Review of Resident #16's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and had one surgical wound. Review of Resident #16's hospital note dated 08/15/25 revealed the resident had a large abscess in his scrotum. A scrotal exploration, incision, and drainage was completed of the abscess. The wound was irrigated and necrotic tissue was debrided. The wound was packed with wet to dry Iodoform gauze. Review of Resident #16's physician order dated 02/08/25 revealed the resident was to be under enhanced barrier precautions (EBPs) which included staff wearing gloves and gown with treatment and/or care. Review of Resident #16's physician's order dated 09/25/25 revealed an order to place gauze packing strips (Iodoform) one-half inch and apply once daily and as needed if saturated, soiled, or dislodged for 20 days. There were also instructions to pack the entire wound loosely. Observation on 09/26/25 at approximately 12:15 P.M. of the signage alerting visitors and staff to the EBPs for Resident #16 revealed a white magnetic sign was attached to the upper right side of the resident's door frame and the sign had the letters EBP at the top and contained pictures of handwashing, a gown, and gloves. Observation on 09/26/25 at 12:19 P.M. of Resident #16's wound care revealed the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #200 completed scrotal wound care wearing only protective gloves. Additional observations revealed LPN #200 assisted the DON with wound care and touched the tray tables, the resident's sheets, and bed then reached with the same gloved fingers into the bottle of Iodoform and pulled out the dressing. LPN #200 then handed the packing to the DON who placed the Iodoform in Resident #16's wound and packed it with a large cotton swab. Interview with the DON and LPN #200 on 09/26/25 at 12:33 P.M. verified they failed to wear gowns during Resident #16's wound care and confirmed proper infection control measures were not maintained when the same gloves used to touch contaminated surfaces were used to directly touch and handle clean wound dressing without cleansing hands and changing gloves. Review of the facility policy titled, Isolation Precautions Process, revised 08/01/22, revealed enhanced barrier precautions will be utilized for residents with wounds. Elements of enhanced barrier precautions included hand washing and gloves and gowns should be worn during high-contact resident care which included wound care (skin opening requiring a dressing). Signage will be posted at the entry to the resident's room to alert them of the need to consult the nurse prior to entering with the nurse providing appropriate personal protective equipment instruction. This deficiency represents non-compliance investigated under Master Complaint Number 2611062.</p>		