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 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Monclova	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, resident interview, staff interview, the facility failed to ensure resident bathing preferences were honored. This affected one (#32) of one resident reviewed for choices. The facility census was 54. Findings include: Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, hypertension, and depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent on staff for bathing. Review of the shower schedule revealed Resident #32 was scheduled for showers on Wednesdays and Saturdays on second shift. Review of the task bathing documentation from 01/01/25 through 03/25/25 revealed the resident was not provided a bath or shower on her preferred days on 01/08/25, 01/18/25, 01/29/25, 03/08/25, and 03/15/25. Further review of the task documentation revealed the type of bathing provided on other days when received was unknown as the staff do not document if the resident received a shower or bath in tasks in the electronic medical record. Review of the nurses progress notes dated 01/01/25 through 03/25/25 revealed the resident had not refused her showers on 01/08/25, 01/18/25, 01/29/25, 03/08/25, and 03/15/25. Interview on 03/24/25 at 10:07 A.M., Resident #32 revealed she preferred showers and had not received her showers as scheduled because the aides would tell her the shower chair was not available. Interview on 03/25/25 at 10:14 A.M., Certified Nursing Assistant (CNA) #292 revealed paper shower sheets were used to document whether a resident received a shower or a bed bath. CNA #292 revealed bathing was documented in the electronic medical record but not the type of bathing provided. Interview on 03/26/25 at 12:51 P.M., the Administrator revealed she was unable to provide the paper shower forms because they were not required and were not part of the medical record. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366361	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Monclova	5069 Otterbein Way Monclova, OH 43542

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/26/25 at 3:04 P.M., the Director of Nursing (DON) revealed the resident's bathing preference was listed at the top of the bathing task. The DON revealed the type of bathing received was not documented in the electronic medical record. The DON revealed when the nursing assistant signed the task as completed it also meant the resident's preference was honored. Interview on 03/26/25 at 3:26 P.M., CNA #211 revealed if a resident received a bedbath instead of a shower then it would be documented on the shower sheet but not in the electronic medical record. Interview on 03/26/25 at 6:36 P.M., CNA #347 revealed in the past the shower chair was not available and the resident was provided a bed bath instead of a shower. CNA #347 revealed bathing was documented in the medical record but not the type of bathing. CNA #347 revealed bed baths and showers were documented on paper shower forms. Interview on 03/26/25 at 3:26 P.M., CNA #211 revealed if a resident received a bedbath instead of a shower then it would be documented on the shower sheet but not in the electronic medical record. Interview on 03/27/25 at 7:32 A.M., the Administrator revealed the facility had no policy regarding resident choices but followed resident rights. Interview on 03/27/25 at 8:32 A.M., Licensed Practical Nurse (LPN) #227 verified there was no documentation showers were given on 01/08/25, 01/18/25, 01/29/25, 03/08/25, and 03/15/25 and stated the resident had a bed bath or shower on other days. LPN #227 revealed it could not be determined by the bathing documentation in the electronic medical record if the resident had received a bed bath or shower.

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NAME OF PROVIDER OR SUPPLIER Otterbein Monclova		STREET ADDRESS, CITY, STATE, ZIP CODE 5069 Otterbein Way Monclova, OH 43542	

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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** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure a resident's representative was notified of a change in condition. This affected one (#10) of one resident reviewed for notification of change of condition. The facility census was 54. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included acute kidney failure, atrial fibrillation, and hypertensive heart disease. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of a nurses note dated 03/25/25 at 3:04 P.M., Resident #10 requested to transfer to the emergency room for increased pain. The resident was offered alternative measures such as pain medication, repositioning, distraction but resident was adamant on going to the emergency room for further evaluation. Review of a nurses note dated 03/26/25 at 12:17 P.M. revealed no documentation the resident's power of attorney/family member was notified of the transfer to the hospital. Interview on 03/27/25 at 8:58 A.M., the Director of Nursing (DON) revealed the resident was his own responsible party. The DON stated in the last couple of years the resident had not been speaking to his family member. The DON verified there was no documentation of attempts to reach the resident's family member and no documentation the resident had requested for his family member not to be contacted. Review of the facility policy Notification of Change of Condition, revised 11/22/21, revealed the facility would notify the resident's representative when there was a need to alter treatment significantly or a decision to transfer or discharge the resident from the facility.

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NAME OF PROVIDER OR SUPPLIER: Otterbein Monclova		STREET ADDRESS, CITY, STATE, ZIP CODE: 5069 Otterbein Way Monclova, OH 43542	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure a nursing plan of care was implemented to address a dependent resident need for assistance with activities of daily living including grooming. This affected one (#53) of 24 residents reviewed for the provision of hygiene and grooming in a facility census of 54. Findings include: Resident #53 admitted to the facility on [DATE] with the diagnoses including, cerebral infarction, type 2 diabetes mellitus, expressive language disorder, gastrostomy, and hypertension. According to the most current minimum data set assessment dated [DATE] noted Resident #53 assessed with severe cognitive impairment, limitation in range of motion to one side upper and lower extremity, dependent on staff for the completion of activities of daily living (ADL), incontinent of bowel and bladder, receives all nutrition via feeding tube, at risk for pressure ulcer development with no current skin breakdown. Observation on 03/24/25 at 9:43 A.M., and 03/25/25 at 6:08 A.M., 8:22 A.M., 11:39 A.M. 12:56 P.M. noted Resident #53 with long jagged fingernails with black/brown debris under the surface. On 03/25/25 at 2:05 P.M. interview with Certified Nurse Aide (CNA) #313 and CNA #274 verified Resident #53 was dependent for bathing and hygiene. Both CNA #313 and CNA #274 confirmed Resident #53 long jagged fingernails with black/brown debris under the surface and were unaware when his fingernails were most recently trimmed. On 03/26/25 at 2:45 P.M. interview with the Director of Nursing verified a nursing plan of care was not developed or contained in the medical record to address Resident #53 dependence on staff for the provision of ADL's.

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NAME OF PROVIDER OR SUPPLIER Otterbein Monclova		STREET ADDRESS, CITY, STATE, ZIP CODE 5069 Otterbein Way Monclova, OH 43542	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure dependent residents were provided with effective or sufficient assistance with activities of daily living including grooming. This affected two (#53 and #11) of 24 residents reviewed for the provision of hygiene and grooming. The facility census was 54. Findings include: 1. Resident #53 admitted to the facility on [DATE] with the diagnosis including, cerebral infarction, type 2 diabetes mellitus, expressive language disorder, gastrostomy, and hypertension. According to the most current minimum data set assessment dated [DATE] noted Resident #53 assessed with severe cognitive impairment, limitation in range of motion to one side upper and lower extremity, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, receives all nutrition via feeding tube, at risk for pressure ulcer development with no current skin breakdown. Observation on 03/24/25 at 9:43 A.M., and 03/25/25 at 6:08 A.M., 8:22 A.M., 11:39 A.M. 12:56 P.M. noted Resident #53 with long jagged fingernails with black/brown debris under the surface. On 03/25/25 at 2:05 P.M. interview with Certified Nurse Aide (CNA) #313 and CNA #274 verified Resident #53 was dependent for bathing and hygiene. Both CNA #313 and CNA #274 confirmed Resident #53 long jagged fingernails with black/brown debris under the surface and were unaware when his fingernails were most recently trimmed. 2. Resident #11 admitted to the facility on [DATE] with the diagnoses including, muscular dystrophy, tortcollis ([NAME] neck), scoliosis, protein calorie malnutrition, morbid obesity, major depressive disorder, anxiety disorder, chronic peripheral venous insufficiency, and anemia. According to the most current minimum data set assessment dated [DATE] assessed Resident #11 with intact cognition, no behavior indicating resistance of care, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, at risk for pressure ulcer development with two stage 4 pressure ulcers. On 07/01/22 a plan of care was revised to address Resident #11 activity of daily living self care and/or physical mobility performance deficit. Interventions included; use of medicated shampoo, requires one person assistance with bathing, total assistance with dressing, requires two staff for personal hygiene. Observation on 03/24/25 at 9:33 A.M., and on 03/25/25 at 6:11 A.M. and 11:17 A.M. noted Resident #11 with the same soiled shirt with food debris, heavy beard growth, unkept and matted hair, and long jagged finger nails. On 03/25/25 at 6:11 A.M. interview with Resident #11 revealed the resident would prefer to be clean shaven, but did not want staff to use a straight razor when shaving him. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/25/25 at 11:45 A.M. with Licensed Practical Nurse (LPN) #352 verified Resident #11 lack of grooming, including bathing, shaving, and clean clothing.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, resident interview, staff interview, review of medical record, and review of facility policy, the facility failed to ensure interventions were in place to promote healing of pressure ulcers. This affected two residents (#8 and #11) of four residents (#8, #10, #11, and #30) reviewed for pressure ulcers. The facility census was 54. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including stage four sacral pressure ulcer, multiple sclerosis (MS), type two diabetes mellitus (DM2), paraplegia, depression, gastro-esophageal reflux disease (GERD), colostomy, neuromuscular dysfunction of bladder, insomnia, anemia, hypertension (HTN), hyperlipidemia, chronic pain syndrome, morbid obesity, non-pressure chronic ulcer of part of left lower leg with unspecified severity, non-pressure chronic ulcer of right ankle with unspecified severity, non-pressure chronic ulcer of buttock with unspecified severity, bullous pemphigoid, urinary tract infection (UTI), unspecified open wound of left ankle, and need for assistance with personal care. Review of the most Medicare Five Day Minimum Data Set (MDS) assessment, dated 03/20/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #8's cognition was intact. Concurrent review of the MDS assessment revealed Resident #8 revealed she was dependent for all of her functional abilities, including rolling left and right. Observation on 03/24/25 at 11:43 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 7:44 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 9:53 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 11:27 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 1:05 P.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 3:09 P.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/26/25 at 6:58 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/26/25 beginning at 7:00 A.M. and continuing until 9:30 A.M. revealed Resident #8 was in her room laying on her back and no staff entered her room to turn and reposition the resident. Observation on 03/26/25 at 10:04 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/27/25 at 7:10 A.M. revealed Resident #8 was laying on her back in her bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 03/25/25 at 3:09 P.M. with Resident #8 revealed staff does not turn and reposition her every two hours. Interview on 03/25/26 at 3:44 P.M. with Certified Nursing Assistant (CNA) #304 revealed she offers to turn and reposition Resident #8 two to three times in her eight-hour shift. Interview on 03/26/25 at 10:31 A.M. with Licensed Practical Nurse (LPN) #350 revealed no aides have reported to her that Resident #8 is refusing to be turned and repositioned. Review of Resident #8's most recent Braden Scale (a tool to evaluate a resident's risk of developing pressure ulcers) Assessment, dated 03/16/25, revealed a score of 14, indicating she was at moderate risk for developing pressure ulcers. Review of the care plan for Resident #8 revealed she has actual skim impairments/pressure ulcer and at risk for additional breakdown related to decreased mobility, a sacrum: stage IV pressure and a stage 3 pressure to right buttock and thigh. The outcome listed for this care area is pressures ulcers will show signs of healing and remain free from infection by the next review date. An intervention dated 06/07/22 revealed the resident needed monitoring, reminding, and assistance to turn and reposition at least every two hours, and more often as needed or requested. Further review of the medical record for the previous three months revealed no documentation that Resident #8 refused to be turned and repositioned. Review of the facility policy titled Skin Care Management, dated 12/09/22, revealed staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes. 15816 2. Resident #11 admitted to the facility on [DATE] with the diagnoses including, muscular dystrophy, tortcollis ([NAME] neck), scoliosis, protein calorie malnutrition, morbid obesity, major depressive disorder, anxiety disorder, chronic peripheral venous insufficiency, and anemia. According to the most current minimum data set assessment dated [DATE] assessed Resident #11 with intact cognition, no behavior indicating resistance of care, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, at risk for pressure ulcer development with two stage 4 pressure ulcers. On 10/09/24 a nursing plan of care was revised to address Resident #11 actual skin impairment related to immobility. Interventions included the following; administer treatments as ordered and monitor for effectiveness. Follow policies/protocols for prevention and treatment of skin breakdown. If resident refuses treatment confer with resident, interdisciplinary team, and family to determine why and try alternative methods to gain compliance. Document alternative methods. According to the medical record on 10/25/24 a physician order was implemented to Resident #11 stage four (IV) pressure ulcers to his lower back and right upper back. The order directed to cleanse with house wound cleanser, then apply Hydrofera Blue (wet with normal saline if hard foam) and apply to wound bed, cover with silicone bordered foam. Complete every two days in the morning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of wound physician evaluation dated 03/20/25 noted Resident #11 assessed with a Stage 4 pressure wound to the right medial upper back with full thickness. Duration was greater than 1089 days, healing potential poor, cluster measurements included; 2.0 centimeters (cm) long by (x) 6.0 cm wide x 0.2 cm deep with moderate serosanguinous drainage. Additionally, a Stage 4 pressure wound to right lower back with full thickness. Duration was greater than 628 days, healing potential poor, cluster measurements included; 6.0 cm x 4.0 cm x 0.1 cm with moderate serosanguinous drainage. Observation on 03/25/25 at 11:17 A.M. noted Licensed Practical Nurse (LPN) #352 attempt to complete skin impairment dressing changes. LPN #352 completed a non-pressure wound dressing change to Resident #11 right arm. Following the dressing change Resident #11 refused to have the stage IV pressure ulcers changed due to anxiety and pain. Review of the medical record lacked documentation or attempts to re-approach Resident #11 to complete the stage IV pressure ulcer wound dressing changes. No documentation indicated the physician was notified of the wound dressing change refusal. On 03/26/25 at 9:40 A.M. interview with LPN #305 revealed she assumed care of Resident #11 at 6:30 A.M. LPN #305 indicated she was unaware Resident #11 had refused the pressure ulcer wound dressing change the previous day or if the dressing had been changed following the refusal. Review of medical record at the time verified no documentation indicating the physician was notified or the refusal or attempts to re-approach resident to change the wound dressing. Observation on 03/26/25 at 11:07 A.M. with LPN #305, Certified Nurse Aide (CNA) #274, and CNA #266 noted Resident #11 to transfer from recliner to bed. Resident #11 shirt was noted with a large amount of drainage clinging to his back. The dressings applied to Resident #11 back were dated 03/23 with yellow green drainage penetrating to dressings. LPN #305 proceeded to obtain wound cleansing solution and moistened the existing dressing, which was clinging to the wound. As LPN #305 pealed the dressing away from the wound a moderate amount of yellow/green drainage was observed on the dressings and caused fresh bleeding. LPN #305 proceeded to discard the existing dressings, cleanse the wounds and applied a new dressing. On 03/26/25 immediately following the wound dressing change LPN #305 confirmed the dressing had not been changed since 03/23/25 as documented in the medical record. Review of facility Skin Care Management Procedure dated revised 12/09/22. Staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes. An evaluation of the dressing if present, is it intact, is there drainage or leakage. Determination of the need for a dressing for an ulcer is based upon the individual practitioner ' s clinical judgment and facility protocols based upon current professional standards of practice. The physician will be notified of all skin areas of concern and consulted for treatment orders. The physician will be notified of risk factors and the development of any area of concerns and consulted for treatment orders. This deficiency represents non-compliance investigated under Complaint Number OH00162263.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure devices to prevent contractures were applied in accordance with physician orders. This affected one resident (#53) reviewed for the application of range of motion interventions. The facility census was 54. Findings include: Resident #53 admitted to the facility on [DATE] with the diagnoses including, cerebral infarction, type 2 diabetes mellitus, expressive language disorder, gastrostomy, and hypertension. According to the most current minimum data set assessment dated [DATE] noted Resident #53 assessed with severe cognitive impairment, limitation in range of motion to one side upper and lower extremity, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, receives all nutrition via feeding tube, at risk for pressure ulcer development with no current skin breakdown. On 03/02/25 a physician order was initiated for the application of a right hand splint to be on during the day and off at bed time (HS). Review of the medical record lacked documentation indicating the right hand splint was applied as ordered. Observations on 03/24/25 at 2:24 P.M., and 03/25/25 at 6:08 A.M., 8:22 A.M., 11:39 A.M., 12:56 P.M. noted Resident #53 in bed without the right hand splint applied. On 03/25/25 at 2:05 P.M. interview with Certified Nurse Aide (CNA) #313 and CNA #274 stated they were unaware of Resident #53 splint, an application schedule, or what staff was to apply the splint. CNA #274 verified the splint was not applied during the shift. Interview on 03/25/25 at 2:08 PM with Licensed Practical Nurse (LPN) #352 confirmed assigned to Resident #53 care on 03/25/25 between 6:30 A.M. and 6:30 P.M. LPN #352 verified the splint was not applied during her shift and was unaware the splint was to be applied. Observation on 03/26/25 at 6:02 A.M. noted Resident #53 in bed with the right hand splint applied. On 03/26/25 at 6:13 A.M. interview with CNA #346 revealed CNA #346 assumed care of Resident #53 between 10:30 P.M. on 03/25/25, and 6:30 A.M. on 03/26/25. CNA #346 was unaware of Resident #53's splint and that it was to be applied through the night. Review of the electronic care card with CNA #346 lacked evidence of Resident #53 having a splint or instructions regarding the application of the splint.

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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** 35033 Based on review of the medical record, observation, resident interview, staff interview, and policy review, the facility failed to ensure medications were secured and not left at the bedside. This affected one (#19) of seven residents reviewed for medications and had the potential to affect two residents the facility identified as cognitively impaired and independently mobile. The facility census was 54. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included dysphagia following cerebrovascular disease, heart failure, chronic respiratory failure, chronic kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. The resident required substantial/maximal assistance with eating. Review of the malnutrition risk care plan last revised 02/14/25 revealed to provide one to one supervision with meals/snacks/fluids. Review of a physician order dated 03/24/25 revealed the resident's medication could be combined, crushed, and administered together. The resident had no orders to self-administer medications. Observation on 03/24/25 at 9:10 A.M. revealed the resident was lying in bed. On the bedside table was a medication cup with a spoon containing medications mixed in pudding. Interview on 03/24/25 at 9:10 A.M., the resident revealed the night nurse had left his medications and had not returned. Interview on 03/24/25 at 9:11 A.M., Licensed Practical Nurse (LPN) #305 revealed she had not yet administered medication to the resident this morning. LPN #305 revealed the medications were left by the previous shift nurse. Interview on 03/26/25 at 7:56 A.M., with LPN #215 verified leaving the medication unattended with the resident. LPN #215 revealed she usually left the medications with the resident and would go back later to check if the resident took the medication but on this day she forgot to go back and check. Review of the policy Medication Administration Procedure, revised 11/09/21, revealed the resident would be observed after administration to ensure the dose was completely ingested.

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NAME OF PROVIDER OR SUPPLIER Otterbein Monclova		STREET ADDRESS, CITY, STATE, ZIP CODE 5069 Otterbein Way Monclova, OH 43542	

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, observation, staff interview, resident interview, and review of a skills procedure, the facility failed to ensure an appropriate diagnosis for the continued use of an indwelling urinary catheter and failed to ensure catheter tubing was secured. This affected one (#48) of two residents reviewed for urinary catheters. The facility identified seven residents with indwelling urinary catheters. The facility census was 54. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure, depressive disorder, urinary tract infection, anxiety, chronic kidney disease stage three, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent for toileting hygiene and occasionally incontinent of bowel and bladder. The resident had an indwelling urinary catheter. Review of the physician orders dated 02/14/25 revealed the resident had a 16 French urinary catheter change as needed. There were no orders for securing the urinary catheter tubing. There was no diagnosis to support the catheter use. Review of the care plan initiated 02/14/25 revealed the resident had a urinary catheter. There were no guidelines for securing the catheter tubing. Interview on 03/25/25 at 9:53 A.M., with Resident #48 and her family member revealed the resident could not stand to be wet from incontinence and needed the catheter because she frequently had to go to the bathroom and was concerned about skin breakdown. The resident revealed not wanting the catheter removed. Observation on 03/25/25 at 11:16 A.M. of Resident #48 revealed Certified Nursing Assistant (CNA) #351 and CNA #271 provided catheter care for the resident. The resident had no device to secure the catheter tubing. Interview on 03/25/25 at 11:16 A.M., CNA #351 and CNA #271 verified the resident's indwelling catheter tubing was not secured. Interview on 03/26/25 at 9:32 A.M., the Director of Nursing (DON) revealed the resident had a diagnoses of urinary retention from the hospital. The DON revealed the physician wanted the resident's catheter removed but the resident continued to refuse the removal of the catheter. The DON revealed the resident had been educated on the risks of not removing the catheter. Review of the undated facility 2025 Skills Checklist Indwelling Urinary Catheter Care and Management, revealed to ensure the catheter was secured properly.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents on psychotropic medication were monitored for adverse consequences, effectiveness, and behavior monitoring. This affected two (#48, and #161) of five residents reviewed for unnecessary medications. The facility identified 28 residents receiving psychotropic medications. The facility census was 54. Findings include: 1. Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure, major depressive disorder, urinary tract infection, anxiety, chronic kidney disease stage three, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the physician orders for 03/2025 revealed an order for bupropion 75 milligrams (mg) every other day for major depressive disorder. An order for fluvoxamine 25 mg at bedtime for anxiety, buspirone 15 mg three times a day for anxiety, escitalopram 20 mg daily for antidepressant. Review of the care plan initiated 02/18/25 revealed the resident utilized antidepressant and antianxiety medications and to monitor for side effects and effectiveness and document. Review of the medication administration record (MAR) from 02/18/25 through 03/25/25 revealed no documentation of monitoring for the side effects and effectiveness of the ordered medications for depression and anxiety. Interview on 03/26/25 at 9:30 A.M., the Director of Nursing (DON) verified there were no orders in place for monitoring the side effects and effectiveness of the medications. 2. Review of the medical record for Resident #161 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, anxiety, delusional disorder, depressive disorder, and hypertension. Review of the admission MDS dated [DATE] revealed the resident had cognitive impairment. Review of the physician orders for 03/2025 revealed an order for Seroquel 100 mg at bedtime for restlessness, Seroquel 50 mg in the morning for restlessness, hydroxyzine 25 mg as needed every six hour for anxiety, trazadone 50 mg at bedtime for restlessness, and sertraline 100 mg two tablets daily for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the care plan initiated 03/20/25 revealed the resident had a behavior of resisting care, yelling out, and restlessness. Further review of the care plan revealed the resident utilized antipsychotic, antidepressant and antianxiety medications and to monitor for side effects and effectiveness and document. Also to review behaviors/interventions and alternate therapies attempted and their effectiveness. Review of the MAR from 03/10/25 through 03/25/25 revealed no documentation of monitoring for the side effects and effectiveness of the ordered medications for depression and anxiety. Interview on 03/26/25 at 9:32 A.M., the DON verified there were no orders in place for monitoring targeted behaviors or for the side effects and effectiveness of the resident's medications. Further interview on 03/26/25 at 1:49 P.M. the DON revealed the resident had an appropriate diagnosis of major depressive disorder for the use the Seroquel but the physician order entered into the electronic medical record had not reflected the appropriate diagnosis. Review of the facility policy Psychotropic Medication Management Policy, revealed an unnecessary drug was any drug used without adequate monitoring or without adequate indication for use.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 15816 Based on observation, staff interview, and review of facility menu, the facility failed to ensure the approved menu was followed as indicated. This affected 12 residents (#1, #6, #9, #15, #16, #18, #21, #29, #30, #37, #47, #52) residing in home number 85. The facility census was 54. Findings include: Observation on 03/24/25 at 12:30 P.M. noted Certified Nurse Aides (CNA) #285 and CNA #351 providing the lunch meal to residents residing in the home. CNA #351 stated the previous weeks menu was posted and those meal items listed were not available. CNA #351 stated no current menu was available and the CNA's were serving residents various items available in the kitchen. CNA #351 and CNA #285 stated they were giving residents the following items; choice of one fish filet, hand full tater (potato) tots, if residents did not want tater tots residents were provided an extra fish filet. Residents were also given, some, potato salad and cut up strawberries. For residents not getting fish the were getting either turkey cold cut sandwich, or a peanut butter and jelly sandwich. Review of facility menu for 03/24/25 lunch noted the following items to be served; three ounce cheeseburger on bun with lettuce, tomato, onion, pickle, four ounces potato salad, four ounces strawberries with whipped cream. On 03/24/25 at 12:46 P.M. interview with Dietetic Technician (DT) #265 verified the home was not following a menu or dietitian calculated portion sizes. Additional interview on 03/25/25 at 09:00 A.M. interview with DT #265 identified 12 of 12 residents (#1, #6, #9, #15, #16, #18, #21, #29, #30, #37, #47, #52) residing in the home that received meals from the facility kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, and review of facility policy, the facility failed to follow proper sanitation and food storage practices. This had the potential to affect all residents who eat food from the facility kitchens. The facility identified that all residents receive food from the facility kitchens. The facility census is 54. Findings include: 1. Observation of the kitchen in house 5069 on 03/24/25 between 7:51 A.M. and 8:05 A.M. revealed the built-in oven under the microwave was dirty with generalized grime and dirt covering the sides and bottom of the oven, butter stored on the counter by the stove, 15 strips of cooked bacon on a plate on the stove-top on a plate, and approximately two cups of scrambled eggs in a bowl. Neither the butter, cooked bacon, or scrambled eggs were stored in a manner to ensure appropriate holding temperatures were maintained to ensure food safety, two packages of Egg-O waffles, one containing five waffles and the other containing six waffles, were both open, unsealed, and undated in the side-by-side freezer in the kitchen, a 64-ounce bag of French fries, approximately two-thirds used, was open, unsealed, and undated, the electronic freezer thermometer in the side-by-side freezer in the kitchen revealed it was not registering a temperature due to low battery, a dirty bottom shelf in the refrigerator in the storage room, one 20-ounce can of [NAME] brand apple pie filling with a dent on the top ring and a dent on the bottom ring, a foul odor was emanating from the dishwasher in the kitchen. Interview with Certified Nursing Assistant (CNA) #276 at the time of observation verified these findings. 2. Observation of the kitchen in house 5076 on 03/24/25 between 9:49 A.M. and 10:03 A.M. revealed the bottom of the in the storage area was dirty, the floor of the refrigerator in the kitchen is dirty, the built-in oven under the microwave was dirty with generalized grime and dirt covering the sides and bottom of the oven, the free-standing standard stove and oven had a dirty oven, and cabinet door faces are dirty throughout the kitchen. Interview with Licensed Practical Nurse (LPN) #221 at the time of observation verified these findings. 3. Observation of the kitchen in house 5090 on 03/24/25 between 10:13 A.M. and 10:21 A.M. revealed the bottom of the refrigerator in the storage area was dirty, bottom shelf in the stand up freezer is dirty, floor in kitchen storage room was dirty (paper and food), one 15-ounce can of beets with a dent in bottom ring, one 19-ounce can of red enchilada sauce with a dent in the side of the can, the built-in oven under the microwave was dirty with generalized grime and dirt covering the sides and bottom of the oven, the free-standing standard stove and oven had a dirty oven. Interview with CNA #298 at the time of discovery verified these findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Food Storage Policy & Procedure, dated 10/01/09 revealed all food is to be stored, labeled, and dated properly to assure stock rotation and prevent food illness.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on observation, staff interview, resident interview, medical record review, and review of the Centers for Medicare and Medicaid Services (CMS) Provider History Profile document, the facility failed to have an effective quality assurance and performance improvement (QAPI) program to address repeated deficiencies identified during four consecutive comprehensive surveys. This had the potential to affected all 54 residents in the facility. The census was 54. Findings include: Review of the CMS Provider History Profile document, with Certification and Survey Provider Enhanced Reporting (CASPER) system data, last updated 03/06/25, revealed the facility was issued a deficiency for not providing services/treatments to prevent/heal pressure ulcers on the three previous comprehensive surveys in 08/2018, 09/2019, and 11/21/22 and during complaint surveys dated 07/26/23 and 11/02/23. During the current comprehensive survey, with exit date 03/27/25, the facility was cited for pressure ulcers for the fourth consecutive comprehensive survey. 1. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including stage four sacral pressure ulcer, multiple sclerosis (MS), type two diabetes mellitus (DM2), paraplegia, depression, gastro-esophageal reflux disease (GERD), colostomy, neuromuscular dysfunction of bladder, insomnia, anemia, hypertension (HTN), hyperlipidemia, chronic pain syndrome, morbid obesity, non-pressure chronic ulcer of part of left lower leg with unspecified severity, non-pressure chronic ulcer of right ankle with unspecified severity, non-pressure chronic ulcer of buttock with unspecified severity, bullous pemphigoid, urinary tract infection (UTI), unspecified open wound of left ankle, and need for assistance with personal care. Review of the most Medicare Five Day Minimum Data Set (MDS) assessment, dated 03/20/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #8's cognition was intact. Concurrent review of the MDS assessment revealed Resident #8 revealed she was dependent for all of her functional abilities, including rolling left and right. Observation on 03/24/25 at 11:43 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 7:44 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 9:53 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 11:27 A.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 1:05 P.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/25/25 at 3:09 P.M. revealed Resident #8 was laying on her back in her bed. Observation on 03/26/25 at 6:58 A.M. revealed Resident #8 was laying on her back in her bed. (continued on next page)

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F 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Note: The nursing home is disputing this citation.

Observation on 03/26/25 beginning at 7:00 A.M. and continuing until 9:30 A.M. revealed Resident #8 was in her room laying on her back and no staff entered her room to turn and reposition the resident.

Observation on 03/26/25 at 10:04 A.M. revealed Resident #8 was laying on her back in her bed.

Observation on 03/27/25 at 7:10 A.M. revealed Resident #8 was laying on her back in her bed.

Interview on 03/25/25 at 3:09 P.M. with Resident #8 revealed staff does not turn and reposition her every two hours.

Interview on 03/25/26 at 3:44 P.M. with Certified Nursing Assistant (CNA) #304 revealed she offers to turn and reposition Resident #8 two to three times in her eight-hour shift.

Interview on 03/26/25 at 10:31 A.M. with Licensed Practical Nurse (LPN) #350 revealed no aides have reported to her that Resident #8 is refusing to be turned and repositioned.

Review of Resident #8's most recent Braden Scale (a tool to evaluate a resident's risk of developing pressure ulcers) Assessment, dated 03/16/25, revealed a score of 14, indicating she was at moderate risk for developing pressure ulcers.

Review of the care plan for Resident #8 revealed she has actual skim impairments/pressure ulcer and at risk for additional breakdown related to decreased mobility, a sacrum: stage IV pressure and a stage 3 pressure to right buttock and thigh. The outcome listed for this care area is pressures ulcers will show signs of healing and remain free from infection by the next review date. An intervention dated 06/07/22 revealed the resident needed monitoring, reminding, and assistance to turn and reposition at least every two hours, and more often as needed or requested.

Further review of the medical record for the previous three months revealed no documentation that Resident #8 refused to be turned and repositioned.

Review of the facility policy titled Skin Care Management, dated 12/09/22, revealed staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes.

2. Resident #11 admitted to the facility on [DATE] with the diagnoses including, muscular dystrophy, tortcollis ([NAME] neck), scoliosis, protein calorie malnutrition, morbid obesity, major depressive disorder, anxiety disorder, chronic peripheral venous insufficiency, and anemia. According to the most current minimum data set assessment dated [DATE] assessed Resident #11 with intact cognition, no behavior indicating resistance of care, dependent on staff for the completion of activities of daily living, incontinent of bowel and bladder, at risk for pressure ulcer development with two stage 4 pressure ulcers.

On 10/09/24 a nursing plan of care was revised to address Resident #11 actual skin impairment related to immobility. Interventions included the following; administer treatments as ordered and monitor for effectiveness. Follow policies/protocols for prevention and treatment of skin breakdown. If resident refuses treatment confer with resident, interdisciplinary team, and family to determine why and try alternative methods to gain compliance. Document alternative methods.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	According to the medical record on 10/25/24 a physician order was implemented to Resident #11 stage four (IV) pressure ulcers to his lower back and right upper back. The order directed to cleanse with house wound cleanser, then apply Hydrofera Blue (wet with normal saline if hard foam) and apply to wound bed, cover with silicone bordered foam. Complete every two days in the morning. Review of wound physician evaluation dated 03/20/25 noted Resident #11 assessed with a Stage 4 pressure wound to the right medial upper back with full thickness. Duration was greater than 1089 days, healing potential poor, cluster measurements included; 2.0 centimeters (cm) long by (x) 6.0 cm wide x 0.2 cm deep with moderate serosanguinous drainage. Additionally, a Stage 4 pressure wound to right lower back with full thickness. Duration was greater than 628 days, healing potential poor, cluster measurements included; 6.0 cm x 4.0 cm x 0.1 cm with moderate serosanguinous drainage. Observation on 03/25/25 at 11:17 A.M. noted Licensed Practical Nurse (LPN) #352 attempt to complete skin impairment dressing changes. LPN #352 completed a non-pressure wound dressing change to Resident #11 right arm. Following the dressing change Resident #11 refused to have the stage IV pressure ulcers changed due to anxiety and pain. Review of the medical record lacked documentation or attempts to re-approach Resident #11 to complete the stage IV pressure ulcer wound dressing changes. No documentation indicated the physician was notified of the wound dressing change refusal. On 03/26/25 at 9:40 A.M. interview with LPN #305 revealed she assumed care of Resident #11 at 6:30 A.M. LPN #305 indicated she was unaware Resident #11 had refused the pressure ulcer wound dressing change the previous day or if the dressing had been changed following the refusal. Review of medical record at the time verified no documentation indicating the physician was notified or the refusal or attempts to re-approach resident to change the wound dressing. Observation on 03/26/25 at 11:07 A.M. with LPN #305, Certified Nurse Aide (CNA) #274, and CNA #266 noted Resident #11 to transfer from recliner to bed. Resident #11 shirt was noted with a large amount of drainage clinging to his back. The dressings applied to Resident #11 back were dated 03/23 with yellow green drainage penetrating to dressings. LPN #305 proceeded to obtain wound cleansing solution and moistened the existing dressing, which was clinging to the wound. As LPN #305 pealed the dressing away from the wound a moderate amount of yellow/green drainage was observed on the dressings and caused fresh bleeding. LPN #305 proceeded to discard the existing dressings, cleanse the wounds and applied a new dressing. On 03/26/25 immediately following the wound dressing change LPN #305 confirmed the dressing had not been changed since 03/23/25 as documented in the medical record. Review of facility Skin Care Management Procedure dated revised 12/09/22. Staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes. An evaluation of the dressing if present, is it intact, is there drainage or leakage. Determination of the need for a dressing for an ulcer is based upon the individual practitioner ' s clinical judgment and facility protocols based upon current professional standards of practice. The physician will be notified of all skin areas of concern and consulted for treatment orders. The physician will be notified of risk factors and the development of any area of concerns 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 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** 35033 Based on review of the medical record, observation, staff interview, review of facility skills checklist and policy review, the facility failed to ensure infection control standards were in place. This affected one (#48) of two residents reviewed for indwelling catheters. The facility identified seven residents with indwelling urinary catheters. The facility census was 54. Findings include: Review of the medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure, depressive disorder, urinary tract infection, anxiety, chronic kidney disease stage three, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent for toileting hygiene and occasionally incontinent of bowel and bladder. The resident had an indwelling urinary catheter. Review of the physician orders dated 02/14/25 revealed the resident had a 16 French urinary catheter change as needed. There were no orders for placement of the drainage bag. Further review of the physician orders revealed the resident had orders for enhanced barrier precautions (EBP). Observation on 03/24/25 at 9:27 A.M. revealed the resident's catheter drainage bag was lying on the floor beneath the recliner chair. Interview on 03/24/25 at 9:29 A.M., Licensed Practical Nurse (LPN) #221 verified the resident's urinary catheter drainage bag was on the floor underneath the resident's recliner chair. Observation on 03/25/25 at 11:16 A.M. of Resident #48 revealed the resident had a enhanced barrier precaution sign on the entry door frame. Certified Nursing Assistant (CNA) #351 and CNA #271 provided catheter care for the resident wearing gloves but no other personal protective equipment including a gown. Interviews on 03/25/25 at 11:21 A.M. with CNA #351 and CNA #271 verified they were not wearing gowns while providing catheter care. Review of the undated facility 2025 Skills Checklist Indwelling Urinary Catheter Care and Management, revealed to ensure the drainage bag was below the left of the resident's bladder but off of the floor. Review of the facility policy Isolation Precautions Process, dated 12/2009 revealed enhanced barrier precautions (EBP) were used for residents with wounds and/or indwelling medical devices including catheters. EBP included the use of gloves and gowns during high-contact resident care including dressing, bathing/showering, changing linens, transferring, providing hygiene, toileting, device care, and wound care.

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 03/27/2025
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, review of the facility electronic medical record (EMR), resident interview, and staff interview, the facility failed to provide a sanitary and comfortable environment. This affected two (#33 and #212) residents of five (#11, #18, #33, #35, and #212) residents reviewed for environment. The facility census was 54. Findings include: 1. Review of the EMR for resident #33 revealed an admitted [DATE] with diagnoses including congestive heart failure (CHF), type two diabetes mellitus (DM2), hypertension (HTN), hyperlipidemia, paranoid schizophrenia, atherosclerotic heart disease of native coronary arteries, gastro-esophageal reflux disease (GERD), neuromuscular dysfunction of bladder, and constipation. Review of the most recent Quarterly Minimum Data Set (MDS) assessment, dated 02/12/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #33 was cognitively intact. Observation on 03/24/25 at 9:12 A.M. of Resident #33's room revealed the windowsill on the bottom of her window was missing and the wind could be heard and felt blowing in, damaged door trim, damaged paint, and an unidentified brown substance splattered and dried onto the doorframe entering the restroom as well as the waste receptacle in the resident restroom. Concurrent observation also revealed debris (hair, food crumbs, and trash) on the floor throughout Resident #33's room. Interview on 03/24/25 at 9:25 A.M. with Licensed Practical Nurse (LPN) #221 verified these findings. 2. Review of the EMR for Resident #212 revealed an admitted [DATE] with diagnoses including aftercare following joint replacement surgery, hyperlipidemia, hypertensive heart disease and chronic kidney disease (CKD), atherosclerotic heart disease, atrial fibrillation (a. fib), vitamin B deficiency, other specified disorders of bone density and structure, depression, hypertension (HTN), gastro-esophageal reflux disease (GERD). Review of the most recent Medicare Five Day Minimum Data Set (MDS) assessment, 03/17/25, revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating Resident #212's cognitive was moderately impaired. Observation on 03/24/25 at 9:39 A.M. revealed damaged paint on the entryway into Resident #212's restroom. Concurrent observation revealed Resident #212's restroom was unkept, with two cups on the restroom floor, a towel on the restroom floor, a towel sitting on a shower chair in the shower, and generalized debris (paper and hair) on the restroom floor. Interview at the time of observation with Resident #212 revealed she took a shower the night prior, on 03/23/25, and the towels remained in the restroom from that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366361	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Monclova	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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/24/25 at 9:47 A.M. with Certified Nursing Assistant (CNA) #308 verified these findings. This deficiency represents non-compliance investigated under Complaint Number OH00162138.