STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365346	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Lebanon Retirement Community	585 North State Route 741 Lebanon, OH 45036

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review and record review, the facility failed to ensure occupied resident rooms were cleaned and maintained in a sanitary condition for two (room [ROOM NUMBER] and room [ROOM NUMBER]) of eight rooms in Magnolia Way. The census was 142.Findings included:1. Review of a document titled, Resident Room Clean Checklist, dated 09/06/25 and signed by Certified Nurse Aide (CNA) #5, for room [ROOM NUMBER] beds A and B, indicated that dusting furniture, windowsill, etc. and removing cobwebs was not completed.An observation of room [ROOM NUMBER] on 09/09/25 at 4:02 P.M. revealed the windowsill had cobwebs.An observation of room [ROOM NUMBER] on 09/10/25 at 11:14 A.M. revealed brown debris scattered on top of the air conditioning unit and cobwebs in the corners of the windowsill. During an interview on 09/10/25 at 11:16 A.M., CNA #5 stated housekeeping did not come to Magnolia and they completed the cleaning. CNA #5 stated staff were given a cleaning list where they initialed what they completed. She stated the process was that each day the CNAs were to clean two resident rooms. CNA #5 stated when in a resident room if they saw something that needed cleaning, they tried to clean it. She stated if they did not get to the room they would tell the nightshift. She stated room [ROOM NUMBER] should have been cleaned on Saturday. She stated she gave the Room Clean Checklist to Assistant Director of Nursing (ADON) #2.During a concurrent interview and observation on 09/10/25 at 11:24 A.M., CNA #5 entered room [ROOM NUMBER] and observed the dirt debris on the top of the air conditioner and the cobwebs in the windowsill and stated it should have been cleaned.During a concurrent interview and observation on 09/10/25 at 11:37 A.M., ADON #2 observed the debris on the top of the air conditioning and cobwebs in the windowsill in room [ROOM NUMBER]. She looked on the Resident Room Checklist and confirmed cobwebs were listed on the form. She stated it was on the form for the CNA to check off, and no one mentioned to her about the debris on the air conditioner or the cobwebs in the windowsill. She stated she would do a maintenance request for the window because there might be something going on with it.2. Review of a document titled, Resident Room Clean Checklist, dated 09/07/25 and signed by CNA #4, for room [ROOM NUMBER] beds A and B, indicated that sweeping under furniture and in the closet and mopping of floors was not completed.An observation of room [ROOM NUMBER] bed A on 09/09/25 at 8:19 A.M. revealed a resident's bed against the wall and the drywall was peeling. Further observation revealed approximately two feet of drywall peelings and dust on the floor.An observation of room [ROOM NUMBER] bed A on 09/10/25 at 11:12 A.M. revealed the resident's bed against the wall but not touching the wall and the same pile of drywall debris and dust was on the floor. The worn area on the wall with the peeling drywall/paper also remained at the head of the bed.During a concurrent interview and observation on 09/10/25 at 11:22 A.M., CNA #5 entered room [ROOM NUMBER] and observed the drywall dust on the floor and stated that it should have been cleaned. The wall with peeling drywall was observed, and she stated that it should be reported to maintenance.During an interview on 09/11/25 at 8:21 A.M., CNA #4 stated they had a sheet they checked off and gave to the nurse, and the nurse gave it to ADON #2. She stated if she did not get to all the cleaning items on the list, she would write on the sheet why or let the other shift know so they could do it. She stated she cleaned room [ROOM NUMBER] on Sunday (09/07/25), and she did not get to everything. She stated she gave report but did not remember if she told the nurse or the next shift that she did not check everything off. She confirmed that she worked 09/10/25 and did not have a chance to clean what she missed.During a concurrent interview and observation on 09/10/25 at 11:31 A.M., ADON #2 observed the drywall debris on the floor in room [ROOM NUMBER] and stated it should have been addressed by staff. She stated that she did not know how long it had been there. ADON #2 stated the nurse aides handed her the daily checklist, and she tried to do rounds each day to address what happened. She stated that if the drywall debris and the scraped-off drywall were there yesterday, it should have been cleaned.Review of an untitled document with a print date of 09/10/25 revealed a list of maintenance work orders from August 2025 to September 2025 for Magnolia Way. The untitled document revealed no work orders for wall damage in room [ROOM NUMBER] until 09/10/25, when it was brought to the facility's attention. In addition, the document revealed no work orders related to room [ROOM NUMBER] until 09/10/25, when the windowsill and debris on the air conditioning unit was brought to the facility's attention. During an interview on 09/10/25 at 3:06 P.M., the Director of Nursing (DON) stated Magnolia Way was considered a small house, and the CNAs were responsible for the cleaning. She stated there were no

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a care plan was developed for a diagnosis of chronic obstructive pulmonary disease. This affected one (#151) of 37 sampled residents reviewed for care plans. The census was 142.Findings included:Review of the medical record revealed the facility admitted Resident #151 on 10/26/23. Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, Alzheimer's disease with late onset, and acute respiratory failure with hypoxia. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/29/25, revealed Resident #151 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS assessment indicated the resident required substantial to maximum assistance from staff for activities of daily living (ADLs) and received supplemental oxygen therapy while a resident. Review of Resident #151's care plan report, initiated on 11/15/23 and last revised on 09/02/25, did not contain a problem statement or interventions for the resident's diagnosis of COPD or supplemental oxygen usage.Review of an undated document titled, Magnolia (MZ-300 Hall), revealed a section labeled, Notes/Expressions, that specifically indicated Resident #151 wore supplemental oxygen at times.Review of Resident #151's hard chart located at the nurses' station revealed a copy of the resident's order summary report dated 08/01/25, and the hard chart did not include a care plan for COPD with interventions. Review of Resident #151's progress note dated 03/05/25 indicated the chief complaint was wheezing and chronic supplemental oxygen needs. The note indicated that a nurse practitioner (NP) spoke with Resident #151's family member to discuss supplemental oxygen use, and the family member was agreeable to supplemental oxygen at night and as needed if oxygen saturation levels dropped below 90 percent (%) during the day. The note revealed the assessment/plans for COPD was to increase the resident's Duoneb nebulizer delivery frequency to every six hours around the clock and change the albuterol to every four hours as needed. In addition, the progress note included the use of two liters of supplemental oxygen via nasal cannula at bedtime and removed in the morning if the resident's oxygen saturation was greater than 90% and continued use during the day if oxygen saturations dropped below 90%. The note revealed for chronic respiratory failure with hypoxia, the NP ordered the decongestant Mucinex 600 milligrams (mg) every 12 hours. The note revealed the NP indicated she reviewed all changes to the care plan with the family member. Review of Resident #151's progress note dated 08/06/25 indicated the chief complaint was that Resident #151 was seen for COPD. The note revealed the assessment/plans indicated to continue the current plan of care and monitor for COPD. An observation on 09/09/25 at 8:29 A.M., revealed Resident #151 was in bed resting with eyes closed with supplemental oxygen delivered via a nasal cannula. The observation also revealed a nebulizer mask and machine laying on the bedside table. An observation on 09/09/25 at 4:02 P.M. revealed Resident #151 was sitting in a wheelchair with a nebulizer treatment currently being delivered via a facemask. An observation on 09/11/25 at 8:17 A.M., revealed Resident #151 lying in bed resting with eyes closed and supplemental oxygen delivered via a nasal cannula. During an interview on 09/11/25 at 8:44 A.M., MDS Coordinator #4 stated she completed the MDS assessments for Resident #151. She stated she completed the MDS assessments quarterly and each assigned discipline created a care plan under a category for whatever concern the resident had. She stated she completed the nursing portions of the care plan and if a resident had COPD, a care plan should be developed. She reviewed Resident #151's care plan and confirmed she could not locate a care plan for the diagnosis of COPD. She stated the development of a care plan for COPD for Resident #151 was overlooked and missed. She stated that respiratory was the resident's primary medical concern, and she should have developed a care plan for COPD for Resident #151.During an interview on 09/11/25 at 4:07 P.M., the Director of Nursing (DON) stated MDS Coordinator #4 and Assistant Director of Nursing (ADON) #2 oversaw developing care plans. She stated care plans were reviewed and updated interventions were added to align with physician orders and diagnoses. She stated a care plan should have been developed for Resident #151's diagnosis of COPD and the care plan interventions should be updated as needed. During an interview on 09/11/25 at 4:10 P.M., the Administrator stated he expected the resident's care plan to outline the care that was needed based on the resident's diagnoses and interventions were to be updated as needed. Review of a facility policy titled, Comprehensive Care Planning Policy, effective 11/13/17, indicated it is the policy of the facility for the interdisciplinary team to develop, implement and evaluate the comprehensive, person-centered plan of care, which includes measurable objectives and

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure enhanced barrier precautions were followed for one (#27) of six residents reviewed for infection control. The census was 142. Findings included: Review of the medical record revealed the facility admitted Resident #27 on 09/11/19. Diagnoses included unspecified displaced fracture of the second cervical vertebra and sequela and unspecified stage pressure ulcer of sacral region.Review of an admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 09/02/25, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident had Stage Two (partial-thickness skin loss with exposed dermis) and a Stage Four (full-thickness skin and tissue loss) pressure ulcers and received pressure ulcer/injury care and an application of a nonsurgical dressing (with or without topical medication) other than to feet during the review period. Review of Resident #27's care plan report included a focus area initiated on 09/02/25, and revised on 09/10/25, that indicated the resident had potential impairment to the skin integrity related to an admission with a Stage Four wound on the sacrum and a Stage Two wound on the upper back. Further review revealed an intervention dated 09/02/25 for the resident to require enhanced barrier precautions (EBP).Review of Resident #27's order summary report with active orders as of 09/11/25 contained an order initiated on 09/10/25, for EBP with gloves and gown with treatment and/or care every shift. An observation on 09/09/25 at 11:35 A.M. revealed Resident #27's door frame contained a magnet that indicated EBP and had pictures of hand washing, gloves, and a gown.During an observation on 09/10/25 at 11:56 A.M., Certified Occupational Therapy Assistant (COTA) #6 entered Resident #27's room and told the resident she would help the resident to clean themselves up and assist Resident #27 with lunch. During a concurrent observation and interview on 09/10/25 at 12:11 P.M., COTA #6 exited Resident #27's room carrying a bag of soiled linen. COTA #6 stated she assisted the resident with toileting and was discarding the soiled brief. COTA #6 stated she only donned a pair of gloves to help with toileting Resident #27. COTA #6 stated she was educated to wear gloves, gown, and a mask to toilet a resident who was on EBP. COTA #6 acknowledged she had worn gloves to assist with toileting, but had not donned a gown during care because she was unaware Resident #27 was on EBP. During an interview on 09/10/25 at 12:25 P.M., Assistant Director of Nursing (ADON) #7 stated residents with wounds, indwelling catheters, and intravenous lines should be on EBP. ADON #7 stated staff were educated to know a resident was on EBP based on orders in the resident's medical record and signage posted on the resident's door. ADON #7 confirmed Resident #27's room door had a sign that indicated EBP and pictures of handwashing, gown, and gloves. ADON #7 indicated all staff should don all personal protective equipment (PPE) listed on the signage to provide care which included incontinence care, blood sugar checks, and any other physical care for residents on EBP. During an interview on 09/12/25 at 4:33 P.M., the Director of Nursing (DON) stated staff were required to wear the appropriate PPE to include a gown and gloves when providing high-contact care such as toileting for residents on EBP. During an interview on 09/12/25 at 5:25 P.M., the Administrator stated the expectation was that staff would follow the precautions for EBP when providing care.Review of a facility policy titled, Isolation Precautions Process, revised 03/26/25, revealed a section titled, Procedure, that specified the facility would use the following precaution categories to help reduce the spread of an infectious agent and/or minimize the transmission of the infection. The policy further revealed a section titled, Enhanced Barrier Precautions, that specified these are used for residents with infection or colonization with a multi-drug-resistant organism when contract precautions do not apply, for wounds, and/or for indwelling medical devices. Elements of Enhanced Barrier Precautions include hand washing (see hand washing procedure), gloves and gowns should be worn during high contact resident care including dressing, bathing/showering, changing linens, transferring (when in a resident room), providing hygiene, toileting, device care (use of a central line, urinary catheter, feeding tube, or tracheostomy), and wound care (a skin opening requiring dressing).This deficiency represents non-compliance investigated under Master Complaint Number 2592669.