

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Lebanon Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **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 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365346
		If continuation sheet Page 1 of 4

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 excuses for them not to clean the rooms. During a follow-up interview on 09/10/25 at 3:41 P.M., the DON stated they did not have a housekeeping policy, but they had a procedure for resident room cleaning that they used. During an interview on 09/11/25 at 12:58 P.M., the Housekeeping Manager stated that for Magnolia Way, the CNAs were responsible for cleaning resident rooms. She stated they never trained any of the CNAs to clean resident rooms and had not been asked to provide training. She stated it was the responsibility of nursing to train the CNAs. She stated that for Magnolia Way they had to create their own cleaning checklists. The Housekeeping Manager stated she was not aware of quality checks for Magnolia Way. During an interview on 09/11/25 at 4:04 PM, the DON stated the CNAs did the cleaning on the days assigned. She stated if they did not complete the cleaning tasks, they needed to let ADON #2 or their supervisor know and follow up. The DON stated the nurses should check too. She stated if there was a major issue they should let maintenance know, and the CNAs could put in a work order. The DON stated it was a team effort. During an interview on 09/11/25 at 4:06 P.M., the Administrator stated staff followed the cleaning schedule, and if they were unable to get to it, they needed to let the supervisor know. Review of a facility document titled, Patient Room Cleaning - Detail Procedure Once Each Week, modified 09/10/25, revealed for staff to dust and clean the patient room from high to low with disinfectant cleaner. Further review revealed for staff to use a disinfectant cleaner and wiping cloth to clean furniture and surface, disinfect the bedframe and mattress while inspecting for tears. Staff are to clean corners and along baseboards using abrasive pad or putty knife and spot clean walls. Staff should continue with daily cleaning procedures. Review of the document titled, Patient Room Cleaning Daily Procedures, modified 09/10/25, revealed staff are to dust mop the floors, inspect the room for quality control, and report maintenance issues to Supervisor. Review of an undated facility document titled, Resident Room Clean Checklist, indicated the Magnolia cleaning schedule for room [ROOM NUMBER] A/B and room [ROOM NUMBER] A/B was on Saturdays. The resident room clean checklist document specified rooms are thoroughly cleaned on these days with other rooms spot cleaned as needed. The resident room clean checklist section titled, Bedroom, revealed a list of cleaning activities. The cleaning activities were to dust furniture, television, bed frame, shelves, tables, windowsill, remove cobwebs, sweep under furniture and in closet, and mop floors (use wet floor sign). This deficiency represents non-compliance investigated under Master Complaint Number 2592669 and Complaint Number 2566253.		

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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. 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		