STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366050	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein-Cridersville	100 Red Oak Drive Cridersville, OH 45806

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of a facility self-reported incident (SRI), review of a witness statement, review of a police report, staff and resident interviews and policy review, the facility failed to ensure a resident's right to privacy was maintained. This affected one (#10) of three residents reviewed for privacy. The facility census was 48. Findings include: Review of medical record for Resident #10 revealed an admission date of 01/06/23. Diagnoses include chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stoke and hemiparesis affecting the right dominant side. The resident remained at the facility. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #10 had a Brief Interview Mental Status (BIMS) score of nine out of 15 indicating impaired cognition. Resident #10 required set up for eating and maximum assistance with toileting hygiene, bed mobility, transfers and showers. Review of a facility SRI documented on 08/07/25 at approximately 8:30 P.M. management was informed State Tested Nursing Assistant (STNA) #111 had allegedly taken a picture of a resident and posted it in a small group chat on social media. STNA #111 was placed on immediate administrative leave. Police interviewed STNA #111 and she admitted to taking the picture of Resident #10 in the bathtub. The police met with Resident #10 and informed her of the incident and she did not want to press charges. Resident #10 was assessed with no adverse findings. The Power or Attorney (POA) and Medical Director were notified of the incident. Resident #10 was assess by both the Medical Director and Psychosocial services with no adverse effects. Staff were interviewed and they denied knowledge of STNA #111 taking pictures of residents. Interviews and skin assessments of residents were completed. Staff education was provided. The allegation was substantiated by the facility. Review of the 08/07/25 written statement of Licensed Practical Nurse (LPN) #100 documented she was informed by the police of an indecent picture posted on social media application of Resident #10 by STNA #111. The DON was notified and LPN #111 was instructed to bring STNA #111 to the nurse's station to speak to the DON. STNA #111 admitted to taking the picture and sharing it on a social media group chat application. LPN #111 was then instructed by the DON to walk STNA #111 to the time clock and to the back of the facility to speak to the police. Further documentation revealed LPN #111 accompanied the police to Resident #10's room when she was informed a picture had been taken of her and she was given the opportunity to press charges and the resident declined. Review of the 08/07/25 police incident report revealed an investigation of voyeurism was initiated at the facility. The victim was listed as Resident #10. Interview on 11/26/25 at 9:23 A.M. with the Administrator, Assistant Director of Nursing (ADON) and Director of Nursing (DON) revealed STNA #111 had taken a picture of Resident #10 while in the whirlpool. STNA #11 had shared the picture with a group of four or five other people on Snapchat. None of the other people work at the facility. One of the girls called the sheriff in her county and they proceeded to contact the Auglaize County [NAME]. The sheriff called the facility and informed staff of the incident and the nurse on duty was contacted. The nurse on duty accompanied STNA #111 during questioning by the police at the facility and then she was walked to the time clock. STNA #111 was suspended pending investigation and subsequently terminated. The DON stated the police spoke to Resident #10 and she did not want to press charges; the DON shared a skin assessment and interview of Resident #10 was completed and not reveal any concerns. Resident #10 was assessed by the Medical Director as well as a psychiatric services and had no negative outcome noted. The staff were interviewed and each denied knowledge of the incident and were not aware STNA #111 had taken any pictures of Resident #10, or any other resident. Interview on 11/26/25 at 11:03 A.M with Resident #10 revealed she was informed by the police STNA #111 had taken a picture of her while she was in the whirlpool. Resident #10 shared she was told the picture was a side view. Resident #10 stated she did not know the picture was being taken by STNA #111. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property revised 10/25/22 documented residents have the right to be free from abuse, neglect, exploitation and misappropriation of property. Review of the facility policy titled, Social Networking Policy revised 03/31/23 documented partners are expected to protect the privacy of residents and elders. Partners may not publicly discuss residents or disclose photographs. Partners are prohibited from displaying private or public information about residents, especially anything that would be deemed as demeaning to residents. The deficient practice was corrected on 08/09/25, when the

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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