STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366368	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Springboro	9320 Avalon Circle Centerville, OH 45458

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and policy review, the facility failed to ensure medication carts were locked. This affected one of four medication carts observed and had the potential to affect 11 Residents (#5, #7, #14, #15, #18, #33, #34, #52, #54, #55, and #57) whose medications were stored in the cart. The facility census was 57.Findings include: Observation of the 300 cottage medication cart on 04/30/26 at 8:10 A.M. revealed it was unlocked and a nurse was not visible near the unsecured medication cart. Interview and observation on 04/30/26 at 8:12 A.M., the Administrator verified the 300 cottage medication cart was unlocked and a nurse was not present in the cottage. The Administrator verified Residents' (#5, #7, #14, #15, #18, #33, #34, #52, #54, #55, #57) medications were stored in the cart. Review of the facility policy titled Medication Storage in the Facility dated May 2022 revealed medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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 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. Based on observation, staff interview and review of the week at a glance menu, the facility failed to ensure the menu portion sizes were followed. This affected twelve (Resident #09, #10, #16, #19, #20, #32, #35, #37, #39, #40, #41 and #51) out of 57 residents that resided in the facility. The facility census was 57. Findings Include:Review of the facility's a week at a glance menu for house 9349 dated 04/27/26 revealed residents on a regular and bite sized diets were to receive five ounces of grilled chicken, four ounces of broccoli, a half of a cup of rice pilaf and one breadstick for lunch on 04/27/26.Observation of the kitchen in house 9349 on 04/27/26 at 12:36 P.M. revealed Certified Nursing Assistant (CNA) #166 was serving residents on regular diets two scoops of broccoli using an unlabeled spoon, a scoop of rice using an unlabeled spoon, a piece of chicken that she cut in half and a breadstick. The CNA #166 was serving residents on bite size diets two scoops of broccoli using an unlabeled spoon, a scoop of rice using an unlabeled spoon, a piece of chicken that she cut in half and then cut into bite size pieces with a pair of kitchen scissors and a breadstick. Interview with the CNA #166 on 04/27/26 at 12:36 P.M., revealed CNA #166 did not know any information about portion sizes for regular or bite size diets. CNA #166 stated she just scooped the rice and broccoli using a metal spoon and gave the residents a piece of chicken and a breadstick. CNA #166 verified she was not following the menu for portion sizes. Interview with the Registered Dietitian (RD) #502 on 04/27/26 at 12:47 P.M., verified there were portion sizes listed on the facility's menu but stated the facility had an open concept kitchen and they did not follow exact portion sizes.

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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 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. Based on observations, staff interviews, facility documentation, review of manufacturers recommendations, and policy review, the facility failed to serve food in a manner that protected against cross-contamination. This affected 21 (Residents #5, #7, #14, #15, #18, #27, #33, #34, #52, #54, #55, #56, #57, #64, #65, #66, #68, #69, #70, #71, and #72) residents. Additionally, the facility failed to maintain appropriate dishwashing equipment. This had the potential to affect 12 (Residents #2, #6, #8, #22, #23, #28, #30, #31, #46, #48, #49, and #50) residents in unit 9335. The facility census was 57.Findings include: 1. Observation on 04/27/26 from 12:13 P.M. to 12:23 P.M. revealed Certified Nursing Assistant (CNA) #124 donned blue disposable gloves and prepared food plates for ten (#27, #56, #64, #65, #66, #68, #69, #70, #71, and #72) residents on the rehab unit including one sloppy joe sandwich, one scoop of macaroni and cheese, one prepared garden salad, and one prepared cup of canned fruit. CNA #124 prepared each sandwich by reaching into a bag with her gloved hands, retrieving a hamburger bun, and opening bun on the plate. She scooped one serving of sauced ground beef on the bottom portion bun and used her gloved hand to place the top bun over the meat to complete the sandwich. After preparing the sandwich, she used her gloved hands to pour canned fruit from the can into a small round, fluted serving dish, and placed one dish on the resident tray. She used her gloved hand to cover the plate with a round metal plate cover on the tray. After preparing three additional trays in the same manner without changing her gloves or sanitizing her hands, she walked in to the pantry, opened a cabinet below the counter and removed a stack of three sliver lids and placed them on the kitchen counter next to the stack of trays. She did not change her gloves or sanitize her hands before preparing four additional trays. CNA #124 changed her gloves without sanitizing her hands before preparing two additional trays in the same manner. During an interview on 04/27/26 at 12:23 PM., CNA #124 verified she was touching buns with gloves after touching other surfaces and utensils without changing gloves or sanitizing hands. 2. On 04/27/26 at 12:13 P.M. CNA #149 was observed preparing meals in the 300 cottage kitchen. CNA #149 was wearing gloves. CNA #149 went to the sink scrubbed dirty dishes and then went to the cupboard for a plate. CNA #149 took the plate and scooped a portion of spaghetti and salad onto the plate. CNA #149 then picked up two breadsticks using gloved hands and put them onto the plate. CNA #149 did not remove gloves and wash hands after scrubbing the dirty dishes and before touching breadsticks and plating food items. Interview with CNA #149 on 04/27/2026 12:16 P.M., verified she had not removed her gloves or washed her hands after scrubbing dirty dishes at the sink. CNA #149 verified she had used the same gloves to wash dirty dishes, plate food items, and touch the breadsticks. Review of facility documentation revealed 11 Residents (#5, #7, #14, #15, #18, #33, #34, #52, #54, #55, #57) eat food from the 300 cottage kitchen. Review of the facility policy titled Food Handling and Preparation Policy & Procedure, dated May 2013 revealed hands are washed before and after handling food, between glove change, and as often as necessary to keep them clean. 3.Observation of the kitchen in House 9336 on 04/27/26 at 10:28 A.M. revealed there was a pack of expired buns in the kitchen dated 04/25/26. Interview with Household Aide (HA) #128 on 04/27/26 at 10:28 P.M., verified there was a pack of expired buns in the kitchen dated 04/25/26. 4.Observation on 04/27/26 at 10:39 A.M. of the kitchen in House 9320 revealed the dishwasher wash (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature was 134 degrees Fahrenheit and the dishwasher rinse temperature was 185 degrees Fahrenheit. Interview on 04/27/26 at 10:39 A.M., with Dietary Technician (DT) #142 verified the dishwasher wash temperature was 134 degrees Fahrenheit and the dishwasher rinse temperature was 185 degrees Fahrenheit. The DT #142 verified the dishwasher wash temperature should be above 155 degrees Fahrenheit. Review of the dishwasher's manufacturer instructions dated September 2024 revealed the dishwasher should have a wash temperature of 155 to 160 degrees Fahrenheit and a rinse temperature of 180 to 195 degrees Fahrenheit.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the resident funds accounting record and policy review, the facility failed to ensure resident funds were conveyed within 30 days of discharge from the facility. This affected one (Resident #73) out of five residents reviewed for resident funds. The facility census was 57.Findings Included:Review of Resident #73's medical record revealed Resident #73 admitted to the facility on [DATE]. Diagnoses included cerebral infarction, adult failure to thrive, osteoarthritis, hypertension, chronic kidney disease, dementia moderate with agitation, and anxiety disorder. Resident #73 discharged from the facility on 10/13/25. Review of Resident #73's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired. Review of Resident #73's resident funds authorization dated 10/03/22 revealed Resident #73's Power of Attorney (POA) authorized Resident #73 to have a resident funds account at the facility. Review of Resident #73's resident funds account quarterly statement from 07/01/25 to 09/30/25 revealed Resident #73 had a beginning account balance of $69.14 and an ending balance of $49.14.Review of Resident #73's resident funds account quarterly statement from 01/01/26 to 03/31/26 revealed Resident #73 had a beginning account balance of $49.14 and an ending balance of $0. Further review of the quarterly statement revealed Resident #73 had a debit of $49.14 on 01/14/26 to close the account.Review of a check to the Treasure of the State dated 01/14/26 revealed a check in the amount of $49.14 was issued to the Treasurer of the State for Resident #73.Interview with Business Office Manager (BOM) #500 on 04/29/26 at 11:07 A.M., verified Resident #73 discharged from the facility on 10/13/25 and Resident #73's resident funds account was not conveyed within 30 days of discharge from the facility. Review of the resident trust policy dated 10/04/18 revealed the facility will close and refund resident trust accounts per regulatory guidelines.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review, the facility failed to ensure a resident had an activities care plan. This affected one (Resident #23) out of 20 residents sampled. The facility census was 57.Findings Included: Review of Resident #23's medical record review revealed Resident #23 admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease with late onset, paroxysmal atrial fibrillation, incisional hernia with obstruction without gangrene, hypertension, pure hypercholesterolemia, sleep apnea, atherosclerotic heart disease of native coronary artery without angina pectoris, generalized anxiety disorder, major depressive disorder, dementia in other diseases classified elsewhere unspecified severity with other behavioral disturbance, acute kidney failure, restlessness and agitation, other vitamin B12 deficiency, iron deficiency anemia, anxiety disorder and major depressive disorder. Review of Resident #23's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and Resident #23 required set up assistance with eating, oral hygiene, and personal hygiene. The interview for daily and activity preferences was conducted on the MDS and Resident #23 reported it was very important to have books, newspapers and magazines to read and to keep up with the news. Resident #23 reported it somewhat important to listen to music he liked.Review of Resident #23's care plan dated 04/28/26 revealed Resident #23 did not have an activities care plan and Resident #23's activities preferences were not listed in the care plan.Interview with the Administrator on 04/29/26 at 11:36 A.M., verified Resident #23 did not have an activities care plan and Resident #23's activities preferences were not listed in the care plan.Review of the policy titled Comprehensive Care Planning, dated 11/13/17 revealed an interdisciplinary team was responsible for developing, implementing and evaluating a comprehensive person centered plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure care plans reflected resident's needs regarding tube feeding. This affected one (Resident #3) out of four residents reviewed for care planning. The facility census was 57.Findings Included:Review of the medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, neurocognitive disorder with Lewy Bodies and dysphagia oropharyngeal phase. Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #3 has severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 00. Resident #3 was dependent for activities of daily living (ADLs) and required a Hoyer lift for transfers.Review of Resident #3's physician's orders and medication administration record revealed the resident was receiving Jevity 1.5 at 30 milliliters (ml) per hour via gastrostomy tube.Review of the care plan dated 02/07/26 revealed Resident #3 was on hospice care/comfort care. Resident does not eat enough to prevent decline. Resident does not want tube feed or intravenous (IV).Review of the same care plan dated 02/07/26 revealed Resident #3 was receiving Jevity 1.5 at 30 ml per hour times 24 hours with 150 ml water flush every four hours.Interview on 04/29/26 at 2:08 P.M., the MDS Nurse #108 and the Director of Nursing (DON) #106 verified the Care Plan dated 02/07/26 documented Resident #3 does not want a tube feeding and also stated Resident #3 was receiving Jevity 1.5 tube feeding. The interviews also revealed Resident #3's daughter does want a tube feeding administered.Review of the policy titled Comprehensive Care Planning Procedure, dated 11/09/17 revealed an interdisciplinary team is responsible for developing, implementing and evaluating the comprehensive, person-centered plan of care. Person-centered is defined as a focus on the resident as the locus of control and support the resident in making their own choices; having control over their daily lives. The care plan is updated on a quarterly basis and with any significant change in resident status.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of manufacturer's instructions, and policy review, the facility failed to ensure insulin pen administration devices were primed. This affected one (Resident #37) out of three residents observed during medication administration. The facility census was 57.Findings include:Review of Resident #37's medical record revealed an admission of 05/14/25. Diagnoses included type two diabetes mellitus, anxiety disorder, chronic kidney disease, and dementia.Review of an annual minimum data set (MDS) dated [DATE] revealed Resident #37 had moderately impaired cognition and received insulin injections.Review of physician orders revealed an order dated 09/26/25 for Admelog SoloStar (a rapid acting insulin) 100 units per milliliter (unit/ml) solution pen-injector. Inject six units subcutaneously before meals related to type two diabetes mellitus with hyperglycemia. Observation on 04/29/26 at 7:31 A.M. revealed Registered Nurse (RN) #312 prepared Resident #37's Admelog SoloStar by attaching a new needle and dialing the dose to six units. RN #312 had not primed the new needle. RN #312 then administered Admelog SoloStar six units to Resident #37's right arm at 7:38 A.M.During an interview on 04/29/26 at 7:41 A.M. RN #312 verified she had not primed Resident #37's Admelog SoloStar pen needle before dialing up the ordered dose of six units. RN #312 stated the needle did not need to be primed.Review of the manufacturer's instructions for an Admelog SoloStar pen-injector revealed a safety check should be performed to ensure the pen is working and getting the correct dose by dialing up two units and pressing the injection button all the way in. Repeat the procedure up to three times until insulin appears. Then select the desired dose.Review of the facility policy titled Insulin Pen Use, dated 05/19/25 revealed to attach a new, appropriately sized insulin pen needle to the insulin pen by screwing or clicking it into place following the manufacturer's instructions. Remove the cap from the pen needle and prime the insulin pen by pointing it up in the air, dialing one or two units on the insulin pen and then fully pressing the plunger or by following the manufacturer's instructions. A drop of insulin should appear at the needle tip. Repeat the priming procedure until a drop appears. Turn the dial on the insulin pen to match the patient's prescribed dose.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interviews, and policy review, the facility failed to provide Enhance Barrier Precautions (EBP) for residents with wounds. This affected two (Residents #67 and #68) of four residents observed for infection control. In addition, the facility failed to ensure appropriate hand sanitization during wound treatments. This affected one (Resident #51) of two residents sampled for wound care. The facility census was 57.Findings include: 1. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Diagnoses included unspecified fracture of the lumbar vertebra, rheumatoid arthritis, and obstructive sleep apnea.admission Minimum Data Set (MDS) assessment not yet completed. Review of the care plan dated 04/24/26 revealed Resident #67 had impaired skin integrity related to surgical wound to back. Interventions included applying back brace for comfort, administering treatments as ordered, completing weekly skin checks, providing pressure-reducing mattress, and turning/repositioning frequently and as needed. Review of the medical record revealed Resident #67 had no orders for Enhanced Barrier Precautions (EBP). Observation on 04/29/26 at 8:53 A.M. revealed there was no sign hanging outside the door to Resident #67's room to alert staff and visitors that Resident #67 was in enhanced barrier precautions. During an interview on 04/29/26 at 8:54 A.M. Registered Nurse (RN) #122 verified Resident #67 had a surgical wound to back with the dressing changed every day and had no order or sign on the door for EBP. 2. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE]. Diagnoses included adult failure to thrive, unspecified anxiety disorders, trigeminal neuralgia, recurrent major depressive disorder, moderate protein calorie malnutrition, and chronic kidney disease stage II. Review of the care plan dated 04/25/26 revealed Resident #68 had impaired skin integrity related to pressure injuries to right lateral hip, coccyx, and right ankle from fall at home. Interventions included administering treatments as ordered, completing weekly skin screens, providing a pressure-reducing mattress, and turning/repositioning frequently and as needed. Review of the medical record revealed Resident #68 had no orders for Enhanced Barrier Precautions. Observation on 04/29/26 at 8:46 AM revealed there was a plastic bin with drawers containing Personal Protective Equipment (PPE) including isolation gowns and boxes of non-latex gloves. There was an EBP sign magnetically attached to the door frame. Certified Nursing Assistant (CNA) #201 entered the room to provide morning care without donning PPE. During an interview on 04/29/26 at 9:01 A.M. RN #122 verified Resident #68 had an ankle wound with treatment and had no order for EBP. During an interview on 04/29/2026 at 9:03 A.M. CNA #201 stated Resident #68 was not on any (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions. CNA #201 verified she had just provided Resident #68 assistance with transferring, dressing, and toileting without wearing any PPE other than procedure gloves. Review of policy titled Isolation Precautions Process revised 03/26/25 revealed Enhanced Barrier Precautions were utilized for residents with wounds for their entire stay. Gowns and gloves were worn during high-contact resident care activities including dressing, bathing, changing linens, transferring in the resident room, providing hygiene, toileting, device care, and wound care with a skin opening requiring a dressing. 3. Review of the medical record revealed Resident #51 admitted to the facility on [DATE]. Diagnoses included senile degeneration of the brain, anxiety disorder, mild protein calorie malnutrition, constipation, atherosclerosis of aorta, weakness, osteoarthritis of left knee and other retention of the urine. Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and Resident #51 required set up assistance with eating. Resident #51 required moderate assistance with oral hygiene and maximal assistance with toileting, upper body dressing, lower body dressing, personal hygiene, rolling left and right, sitting to lying, lying to sitting, sitting to standing, and chair transfers. Resident #51 was dependent with showering, putting on and taking off footwear, toilet transfers, and tub transfers. Review of a physician order dated 04/09/26 revealed Resident #51 was ordered to cleanse the left heel with normal saline, apply skin prep and a bordered gauze every day and as needed. Review of a wound care note dated 04/23/26 revealed Resident #51 was seen by Nurse Practitioner (NP) #501. Resident #51 was on hospice and was being followed by management of her left heel. Resident #51 had in house acquired Skin Changes at Life's End (SCALE) wound to her left heel that was 3.1 centimeters (cm) in length by 2.5 cm in width by 0.1 cm in depth. Observation of Registered Nurse (RN) #132 completing wound care on Resident #51's left heel on 04/29/26 at 4:12 P.M. revealed RN #132 donned her gown and entered Resident #51's room. RN #132 washed and dried her hands and donned her gloves. RN #132 used the bed remote that was previously in Resident #51's hands to raise the bed. RN #132 then stated that she left her biohazard bag outside of the room. RN #132 lowered the bed using the bed remote and left the room to get the biohazard bag. RN #132 returned to the room without changing her gloves and placed the biohazard bag on the bed. RN #132 raised Resident #51's bed up using the bed remote and RN #132 removed Resident #51's sock and a dressing that was dated 04/28. RN #132 placed the dressing in the biohazard bag. Resident #51 had a circular dime sized wound on her left heel that was scabbed over with a red and white border around the wound. Without changing gloves RN #132 cleansed Resident #51's wound with normal saline and patted the wound dry. RN #132 wiped the wound with skin prep and applied a foam bordered dressing. RN #132 removed her gloves and gown and washed her hands. Interview with RN #132 on 04/29/26 at 4:24 P.M., verified she had not washed her hands or donned new gloves after touching Resident #51's bed remote, leaving the room to get the biohazard bag or after removing Resident #51's soiled dressing. RN #132 verified she removed Resident #51's soiled dressing to her left heel wound, cleansed Resident #51's wound with normal saline, patted Resident #51's wound dry, applied skin prep to Resident #51's wound and applied a new bandage to Resident #51's heel wound without changing her gloves or washing her hands. RN #132 stated she only had to wash her hands and don new gloves at the beginning of wound care because it was not a sterile (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure. Review of the facility policy titled Foam Dressing Application revealed staff should complete wound care in the following order. Staff should verify the practitioner's orders, gather and prepare the necessary equipment and supplies, perform hand hygiene, confirm the resident's identity using at least two identifiers, provide privacy, explain procedures to the resident, screen for and assess for pain, treat for pain, raise the head of the bed to waist level before providing care, perform hand hygiene, position the resident in a way that maximizes comfort while allowing easy access to the wound site, open the packages of supplies, perform hand hygiene, put on gloves and other personal protective equipment as needed, remove the existing dressing gently, discard the soiled dressing in an impervious plastic trash bag to help avoid spreading infection, assess the wound, clean the resident's wounds using a technique that is appropriate for the wound type and location, remove and discard gloves, perform hand hygiene, put on a new pair of clean gloves, blot the surrounding dry skin using a sterile gauze pad, apply a topical agent using a sterile cotton tipped swab following safe medication administration practices if prescribed, remove the protective film from the foam dressing, lay the dressing gently over the resident's wound and smooth the dressing over the wound without stretching the dressing following the manufacturer's instructions for use, return the bed to the lowest position, discard used supplies in appropriate receptacles, remove and discard your gloves and other personal protective equipment if worn, and perform hand hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366368	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Springboro	9320 Avalon Circle Centerville, OH 45458

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of the Centers for Disease Control and Prevention (CDC) recommendations, the facility failed to ensure a pneumococcal vaccine was offered to a resident. This affected one (Resident #43) out of five residents reviewed for vaccinations. The facility census was 57.Findings Included:Review of the medical record revealed Resident #43 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, hypertension, dysphagia, hyperlipidemia, spinal stenosis, heart failure, constipation, dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, major depressive disorder, epilepsy, generalized anxiety disorder and insomnia.Review of Resident #43's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately cognitively impaired and required set up assistance with eating. Resident #43 required supervision with oral hygiene and personal hygiene and maximal assistance with toileting, showering, and lower body dressing. Review of Resident #43's pneumococcal vaccine consent dated 06/25/25 revealed Resident #43's power of attorney (POA) neither consented or declined the pneumococcal vaccine. The consent stated Resident #43 had received the PPSV23 (Pneumovax 23) vaccine on 04/23/14.Review of Resident #43's medication administration record (MAR) from 04/06/25 to 04/30/26 revealed Resident #43 was not provided any additional pneumococcal vaccines. Interview with the Administrator on 04/28/26 at 4:25 P.M., verified Resident #43's POA neither consented or declined the pneumococcal vaccine on 06/25/25. The Administrator also verified there was no information related to Resident #43 being offered or declining the PCV20, PCV21 or the PCV15.Review of the CDC's pneumococcal vaccine timing for adults job aid dated March 2025 revealed adults over the age of 50 years and over that have received the PPSV23 at any age should have the option to receive the PCV20 or PCV21 in more than one year or the option to receive the PCV15 in more than one year.