STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366376	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Middletown	105 Atrium Drive Franklin, OH 45005

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 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. (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 0689 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 NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, facility investigation review, observations, staff and resident interviews, manufacturer instructions and facility policy review, the facility failed to ensure a resident's wheelchair was secured in the facility's wheelchair van resulting in the wheelchair tipping over during transport. This affected one (#14) of three residents reviewed for accidents. The facility census was 53. Findings include: Review of Resident #14's chart revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with exacerbation, centrilobular emphysema, paroxysmal atrial fibrillation, , malignant neoplasm of unspecified part of right bronchus or lung, hypertension, dysphagia, malignant neoplasm of lower lobe left bronchus or lung, acquired absence of right leg above the knee, peripheral vascular disease, chronic pain and hyperlipidemia.Review of Resident 14's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and the resident #14 required moderate assistant sitting to standing, and transfers.Review of Resident #14's progress note dated 09/24/25 at 3:45 P.M., revealed Resident #14 was sent to the emergency department (ED) from her appointment.Review of Resident #14's progress note dated 09/24/25 at 3:49 P.M., revealed Resident #14 required emergency services during her transport and emergency medical services (EMS) (911) was called. Resident #14 was taken to the hospital by EMS. Resident #14's daughter was called by the facility at 3:17 P. M. and a voicemail was left notifying Resident #14's daughter to call Registered Nurse (RN) #125 back. Review of Resident #14's progress note dated 09/24/25 at 5:45 P.M., revealed Resident #14 returned from the Emergency Department (ED) with orders for Tylenol which the resident already had in place Resident #14 was transferred to her chair and was eating dinner. Resident #14 was placed on neurological (neuro) checks.Review of Resident #14's hospital ED note dated 09/24/25, revealed Resident #14 presented in the ED with a head injury after the wheelchair she was seated in tipped backwards while she was riding in a wheelchair van. Resident #14 was on blood thinners and denied significant any complaints. Resident #14 had tenderness to the back of the head. A computed tomography (CT) of the head was completed with no acute intracranial processes and a CT of the cervical spine without contrast was completed with no acute displaced fracture. Resident #14 was diagnosed with a closed head injury, ordered to receive Tylenol and released. Review of CNA #140's witness statement dated 09/24/25, revealed the statement was taken over the phone by CNA #58. CNA #140 reported CNA #118 did not want to take Resident #14 to the appointment so CNA #140 told her that she would complete the last two check and changes and take Resident #14 to the appointment if CNA #118 would load Resident #14 into the van and have her ready to go. CNA #118 called CNA #140 when she was parked in front of the house and CNA #140 went outside and got into the van. CNA #118 told CNA #140 that Resident #14 was ready to go. CNA #140 greeted Resident #14, CNA #140 fastened her own seatbelt and began driving towards the appointment. As CNA #140 approached the intersection to get onto the interstate, the traffic light was red. When the light turned green, CNA #140 made a left turn to get onto the ramp and while making the left turn, CNA #140 saw Resident #14's leg lift and her wheelchair tipped backwards. CNA #140 heard and saw her hit her head on the wheelchair ramp. CNA #140 immediately pulled the van over to the right side of the road, got out, and opened the back door to check on Resident #14's condition. Resident #14 told CNA #140 she was okay, and this wasn't her fault. Resident #14 stated CNA #118 did not finish locking the wheelchair. CNA #140 told Resident #14 that she could not move her until she was assessed. CNA #140 called Licensed Practical Nurse (LPN) #129 and LPN #129 who CNA #140 to call emergency medical services (EMS) due to the head impact. While waiting, Resident #14 unbuckled her seatbelt and rolled onto her side. CNA #140 called EMS and waited for EMS to arrive. When EMS arrived, Resident #14 initially said she was fine, but they encouraged her to be evaluated. Resident #14 agreed and left with EMS for further evaluation. CNA #140 took the van back to the facility. The statement was signed by CNA #140. Review of CNA #118's witness statement dated 09/24/25, revealed the statement was taken over the phone by CNA #58. CNA #118 reported CNA #140 offered to handle the appointment, but they still had two residents that needed to be changed. CNA #140 stated she would take care of doing those check and changes if CNA #118 could go ahead and get Resident #14 loaded into the van. CNA #118 proceeded to load Resident #14 in front of the house where she resided. CNA #118 secured the back