

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Otterbein Middletown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, and policy review, the facility failed to ensure potentially hazardous chemicals were not accessible to residents. This had the potential to affect 12 (#01, #05, #06, #07, #09, #10, #12, #27, #50, #51, #60, and #68) cognitively impaired and independently mobile residents who resided in Houses #106 and #109. The facility census was 50. Findings include: 1. Observation on 01/05/26 at 9:26 A.M. in House #109, revealed an unlocked cabinet below the sink, which contained 2 containers, one gallon each, of liquid dish machine detergent. Each container of liquid dish machine detergent contained the following warning: Danger: causes severe skin burns and serious eye damage. Harmful if swallowed and Keep out of reach of children. Continued observation revealed an additional two containers, one gallon each, of concentrated crystal dri rinse aid. Each container of the rinse aid contained the following: Warning: causes serious eye irritation and skin irritation and Keep out of reach of children. Interview at the time of the observation Dietetic Technician (DT) #383 verified the four containers of chemicals were not secured. Observation on 01/05/2026 at 9:28 A.M. of the kitchen in House #109 revealed a spray bottle labeled Xcelente multi-purpose cleaner half full of liquid located in an unlocked cabinet under the kitchen sink. The bottle labeled Xcelente included a warning on the label keep out of reach of children. Interview on 01/05/2026 at 9:29 A.M., DT #383 confirmed a bottle labeled Xcelente multi-purpose cleaner was located in an unlocked cabinet under the kitchen sink in building 109. Further interview with DT #383 revealed the bottle labeled Xcelente multi-purpose cleaner should have been located in a locked cabinet. Interview on 01/05/2026 at 10:23 A.M. with Certified Nursing Assistant (CNA) #336 revealed that approximately half of the residents in House #109 were diagnosed with dementia or other memory related issues. 2. Observation on 01/06/26 at 3:44 P.M. in House #106 revealed an unlocked cabinet in the kitchen which contained one gallon of concentrated liquid dish machine detergent. The container of liquid dish machine detergent contained the following warning: Danger: causes severe skin burns and serious eye damage. Harmful if swallowed and Keep out of reach of children. Interview at the same time, CNA #386 verified the concentrated liquid dish machine detergent was not secured and should be kept in a locked cabinet. Review of a document titled Storage and Use of Poisonous Substances Policy & Procedure (cleaning supplies, pesticides, etc.) with a revised date of May 2013 revealed Detergents and sanitizers are permitted to be stored in the locked cabinet under the sink next to the dishwasher. Other items are stored in locked cabinets in the dirty utility room.		

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 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 observation, staff interview, and policy review, the facility failed to ensure food was stored and prepared in a manner to prevent the potential spread of foodborne illness. The facility also failed to ensure kitchen equipment was maintained in a clean and sanitary manner. This had the potential to affect 31 residents (#01, #04, #05, #06, #07, #09, #10, #12, #14, #17, #20, #22, #27, #30, #33, #35, #47, #50, #51, #52, #53, #57, #60, #65, #67, #68, #75, #76, #77, #78, and #79) who resided in Houses #105, #106, and #109. The facility census was 50. Findings include: 1. Observation on 01/05/26 at 9:21 A.M. in House #109, revealed a bag of salad mix in the bottom drawer of the refrigerator, with an open date of 01/01/26, was unsealed. Upon lifting the bag of salad out of the drawer, the contents fell out of the bag onto the floor. Interview at the time of the observation, Dietetic Technician (DT) #383 verified the salad mix was opened and not sealed. Observation on 01/05/26 at 9:22 A.M. in House #109 revealed the oven was coated in a thick brown film throughout. Interview at the time of the observation, DT #383 verified the oven was coated in a thick brown film throughout and was in need of cleaning. Observation on 01/05/26 at 9:30 A.M., in House #109, revealed the air fryer was coated in a thick brown residue and did not appear to have been cleaned after multiple uses. Interview at the same time, DT #383 verified the air fryer was coated in a brown residue and in need of cleaning. 2. Observation on 01/05/26 at 9:41 A.M. in the refrigerator of House #105 revealed the following: A) a large pitcher of pineapple in juice which contained two open dates, 12/26 and 01/01, and did not specify the contents. B) a bag of carrots which was unopened, with a best by date of 12/04/25. C) a bag of carrots, opened and twisted at the top, opened on 12/21/25 and with a best by date of 12/29/25. D) a bag of brown celery, not sealed and not dated. E) a bag of unopened salad mix with a best by date of 12/25/25. F) a container of yogurt in the freezer with a best by date of 10/26/25, and silent for a date it was frozen. G) a bag of mixed fruit, dated 12/3, which was wide open and the fruit was covered in a thick layer of ice crystals. Interview at the time of the observations, DT #383 verified the pitcher of pineapple in juice was not labeled with its contents and had two open dates, the two bags of carrots were past the best by date and one was open, the bag of celery was brown, not sealed and not dated, the bag of salad mix and yogurt were past the best by dates, and the bag of fruit was not sealed and covered in ice crystals. Observation on 01/05/26 at 9:48 A.M. of the dry storage in House #105 revealed a 9 by 13 pan with a frosted cake, approximately half remaining, with no date, an open bag of powdered sugar in a ziplock bag that was not sealed, two open boxes of baking soda in ziplock bags that were not zipped, and an open bag of flour, rolled on top, torn on the sides, and contents on the shelf. Interview at the time of the observations, DT #383 verified the cake was not labeled, powdered sugar and baking soda were not sealed, and the flour was unsealed and spilling out onto the shelf. Observation on 01/05/26 at 9:56 A.M. in the kitchen of House #105, revealed the hood slats were coated in a dark grey fuzzy substance, the oven was coated in a thick brown substance, and the air fryer was coated in a thick brown residue and did not appear to have been cleaned after multiple uses. Interview at the same time, DT #383 verified the hood slats were coated in a dark grey fuzzy substance, the oven was coated in a thick brown substance, and the air fryer was coated in a brown residue and all were in need of cleaning. Review of the facility policy titled, Food Storage Policy and Procedure, dated 05/2013, revealed food should be stored, labeled, and dated to assure stock rotation and prevent food illnesses. Canned fruit should be placed in a container with the name and date refrigerated. Baking goods are marked with the month and day and placed in dry storage. 3. Observation on 01/07/26 at 7:35 A.M. in House #106 revealed Certified Nursing Assistant (CNA) #327 preparing sausage links for the breakfast meal. CNA #327 was observed reaching in the pan with her bare hands, touching the sausage. Interview on 01/07/26 at 7:37 A.M., CNA #327 denied touching the sausage links with her bare hands, and stated she was reaching in the pan trying to pick something out. CNA #327 verified she should not have reached into (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the pan with bare hands due to the potential contact with the food and cooking surface. Review of the facility policy titled, Food Handling and Preparation Policy and Procedure, dated 05/2013, revealed food was to be prepared using only clean, sanitized utensils.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and policy review, the facility failed to follow appropriate infection control practices. This affected three residents (#19, #48, and #80) and had the potential to affect all nine residents (#19, #24, #26, #32, #48, #59, #66, and #74) who reside in House #102. The facility census was 50. Findings include: 1. Review of the medical record for Resident #19 revealed an admission date of 12/18/25. Diagnoses included bacterial infection, bacteremia, paroxysmal atrial fibrillation, alcoholic cirrhosis of liver with ascites, type two diabetes mellitus with diabetic neuropathy, hypertension, heart failure, other low back pain, hyperlipidemia, gout, and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively intact. Resident #19 was assessed to require setup assistance for oral and personal hygiene, substantial/maximal assistance for toileting and lower body dressing, partial/moderate assistance for bathing and bed mobility, supervision for upper body dressing, and was independent for eating. Review of the active physician orders revealed an order dated 12/18/25 for enhanced barrier precautions. Observation on 01/05/26 at 10:07 A.M. revealed Resident #19 had a cart outside the room with personal protective equipment (PPE). There was no signage outside the door that indicated the type of precautions Resident #19 was on. Interview on 01/05/26 at 10:08 A.M. with Certified Nurse Aide (CNA) #323 verified there was no sign on Resident #19's door. 2. Review of the medical record for Resident #48 revealed an admission date of 01/06/26. Diagnoses included acute kidney failure, type two diabetes mellitus without complications, chronic cough, and hyperlipidemia. Review of the admission MDS assessment dated [DATE] revealed the assessment had not been completed yet. Review of the active physician orders revealed an order dated 01/06/26 for enhanced barrier precautions. Observation on 01/07/26 at 8:14 A.M. revealed Occupational Therapist (OT) #500 exited Resident #48's room while wearing gloves. OT #500 removed her gloves and discarded them in a nearby trashcan and did not sanitize her hands. There was an enhanced barrier precautions sign on the door that instructed everyone to sanitize their hands after leaving the room. Interview on 01/07/26 at 8:15 A.M. with OT #500 confirmed she had not sanitized her hands after removing her gloves. 3. Review of the medical record for Resident #80 revealed an admission date of 01/04/26. Diagnoses included influenza due to other identified influenza virus with other respiratory manifestations, acute respiratory failure with hypoxia, acute kidney failure, anxiety disorder, chronic kidney disease stage three b, and hyperlipidemia. Review of the admission MDS assessment dated [DATE] revealed the assessment had not been completed yet. Review of the active physician orders revealed an order dated 01/04/26 for contact isolation due to influenza. Observation on 01/05/26 at 9:31 A.M. revealed Resident #80 had a cart outside her room for PPE. There was no signage outside the door that indicated the type of precautions Resident #80 was on. Interview on 01/05/26 at 9:32 A.M. with OT #500 verified there was no sign outside the door related to the type of precautions Resident #80 was on. Review of the facility policy titled Hand Hygiene Procedure, revised 03/27/25, revealed hand hygiene should be performed after removing PPE. Review of the facility policy titled Isolation Precautions Process, revised 03/26/25, revealed signage for transmission based precautions would be posted at the entry to the resident's room to alert them of the need to consult the nurse prior to entering.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and policy review, the facility failed to ensure advanced directives were correct. This impacted two (Residents #02 and #07) out of three residents reviewed for advanced directives. The facility census was 50. Findings include:1. Review of the medical record for Resident #02 revealed an admission date of 02/24/22. Diagnoses included dementia severe with psychotic disturbance, atrial fibrillation, hypertension, anemia, congestive heart failure, other asthma, vitamin deficiency, and hyperlipidemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #02 had severely impaired cognition. Resident #02 was assessed to require supervision for eating, partial/moderate assistance for oral and personal hygiene, substantial/maximal assistance for upper body dressing, and was dependent on staff for toileting, bathing, lower body dressing, bed mobility, and transfer. Review of the active physician orders revealed an order dated 03/11/25 for Do Not Resuscitate Comfort Care (DNRCC). Review of the plan of care revised on 05/09/25 revealed Resident #02 had a code status of DNRCC. Review of the document titled DNR ORDER FORM, dated 03/11/25, revealed Resident #02 had a code status of DNRCC-Arrest checked instead of DNRCC. Interview on 01/06/26 at 1:39 P.M. with Social Worker #314 verified the physician order was for DNRCC but the signed DNR form was for DNRCC-Arrest. 2. Review of medical record of Resident #07 revealed an admission date of 04/11/2024. Diagnoses included type II diabetes mellitus with diabetic polyneuropathy, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, unspecified, and cerebral infarction, unspecified. Review of MDS assessment dated [DATE] revealed Resident #07 had severe problems with thinking and memory and demonstrated no behaviors. The resident utilized a walker, was independent with eating, upper body dressing, and personal hygiene, set up assistance for oral hygiene, supervision assistance for lower body dressing, sit-to-stand, bed to chair and toilet transfers, and ambulation, and moderate assistance for toileting, bathing, and tub transfers. Record review on 01/06/2026 at 9:50 A.M. of Resident #07's paper medical record revealed a document titled DNR Order Form dated 03/14/2024 which indicated the resident's code status was Do Not Resuscitate-Comfort Care Arrest (DNR-CCA). Record review of Resident #07's Electronic Medical Record (EMR) revealed a physician order dated 08/04/2025 which indicated Resident #07's code status was Do Not Resuscitate-Comfort Care (DNR-CC). Further EMR review revealed a care plan dated 11/27/2025 indicated a code status of DNR-CC. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/06/2026 at 2:16 P.M. with Licensed Practical Nurse (LPN) #377 confirmed documentation in Resident #07's paper medical record documented a code status of DNR-CCA on a document titled DNR Order Form with a signature date of 03/14/2024. Continued interview with LPN#377 confirmed Resident #07's EMR documented a code status of DNR-CC. Review of a document titled Advance Directives Policy with a revised date of 03/19/2025 defined DNR Identification as The standard forms of identification approved by the facility, which record a resident's status as either a DNR Comfort Care resident or a DNR Comfort Care-Arrest resident. This document further states, The facility will also determine whether the resident's physician issued a DNR Order in another setting (e.g., hospital, home) and whether the resident would like a DNR Order issued while in the facility. The Advanced Directives Policy further states, If applicable, a DNR Order will be obtained from the resident's physician and placed in the medical record.		

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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. Based on observation, resident and staff interview the facility failed to maintain a clean environment. This affected one (#20) of one resident reviewed for a clean environment. The facility census was 50. Findings include: Review of Resident #20's medical record revealed admission to facility on 12/12/2025 with diagnoses of osteochondropathies to left ankle and foot, acute osteomyelitis of left ankle and foot, congestive heart failure, and generalized anxiety disorder, Review of the Minimum Data Set (MDS) assessment revealed Resident #20 had a moderate cognitive impairment. The resident was independent with eating, required setup cleanup assistance with oral hygiene, substantial/maximal assistance with toileting and bathing, Resident #20 utilized a wheelchair for mobility. Observation on 01/06/26 at 10:33 A.M. in Resident #20's room revealed ceiling vent was heavily coated in a dark grey fuzzy material. Interview on 01/06/26 at 2:41 P.M. with Resident #20 in Resident #20's room revealed resident was concerned about dust build up on ceiling vent, stating that vent needs to be cleaned. Interview on 01/06/26 at 2:41 P.M., Certified Nursing Assistant (CNA) #348 confirmed the ceiling vent in Resident #20's room was heavily coated in a dark grey fuzzy material and needed to be cleaned.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed in a timely manner. This affected three (#22, #20 and #19) of three residents reviewed for admission MDS assessments. The facility census was 50. Findings include: 1. Review of the medical record of Resident #22 revealed an admission date of 12/12/25. Diagnoses included bacterial infections of unspecified site, hypertension, and scoliosis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the assessment was not completed until 12/30/25. The resident had intact cognition, was independent with eating, required substantial/maximal assistance with toileting, bathing, and was dependent for bed mobility. 2. Review of the medical record for Resident #20 revealed an admission date of 12/12/2025. Diagnoses included osteochondropathies to left ankle and foot, acute osteomyelitis of left ankle and foot, congestive heart failure, and generalized anxiety disorder. Review of the admission MDS assessment dated [DATE] revealed the assessment was not completed until 12/29/25. Resident #20 had a moderate cognitive impairment, was independent with eating, required setup cleanup assistance with oral hygiene, substantial/maximal assistance with toileting and bathing, and Resident #20 utilized a wheelchair for mobility. 3. Review of the medical record for Resident #19 revealed an admission date of 12/18/25. Diagnoses included bacterial infection, bacteremia, paroxysmal atrial fibrillation, alcoholic cirrhosis of liver with ascites, type two diabetes mellitus with diabetic neuropathy, hypertension, heart failure, other low back pain, hyperlipidemia, gout, and congestive heart failure. Review of the admission MDS assessment dated [DATE] revealed the assessment was not completed until 01/07/26. Resident #19 had intact cognition, required setup assistance for oral and personal hygiene, substantial/maximal assistance for toileting and lower body dressing, partial/moderate assistance for bathing and bed mobility, supervision for upper body dressing, and was independent for eating. Interview on 01/07/26 at 3:26 P.M., Registered Nurse (RN) #344 verified MDS assessments for Residents #22, #20, and #19 were not completed in a timely manner. RN #344 verified admission MDS assessments should be completed within 14 days of admission.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to timely arrange podiatry services. This affected one (Resident #54) out of one resident reviewed for ancillary services. The facility census was 50. Findings include: Review of the medical record for Resident #54 revealed an admission date of 08/18/25. Diagnoses included type two diabetes mellitus with diabetic chronic kidney disease, wedge compression fracture of second lumbar vertebra subsequent encounter for fracture with routine healing, hypertension, paroxysmal atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic kidney disease stage three, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was cognitively intact. Resident #54 was assessed to require supervision for oral hygiene, toileting, upper body dressing, personal hygiene, bed mobility, and transfer, partial/moderate assistance for bathing, substantial/maximal assistance for lower body dressing, and was independent for eating. Review of the plan of care initiated on 10/17/25 revealed Resident #54 had diabetes mellitus and was at risk for complications. Interventions included refer to podiatry as needed. Observation on 01/07/26 at 8:33 A.M. of Resident #54's right foot revealed her toenails were thick and some were over half an inch long. Resident #54 reported her toenails were long and painful. Interview on 01/07/26 at 8:34 A.M. with Certified Nurse Aide (CNA) #341 verified Resident #54's toenails were thick and over half an inch long. Interview on 01/07/26 at 11:03 A.M. with Resident #54's daughter revealed she had asked facility staff multiple times to address Resident #54's toenails.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure medical records were updated in a timely manner. This affected one (#52) of two residents reviewed for care conferences. The facility census was 50. Findings include: Review of the medical record of Resident #52 revealed an admission date of 10/04/24. Diagnoses included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, lung cancer, hypertension, hypothyroidism, dysphagia, breast cancer, anxiety, peripheral vascular disease, and drug-induced constipation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was independent with eating, required supervision with toileting and bed mobility, partial/moderate assistance with bathing, and substantial/maximal assistance with transfers. Review of the medical record revealed care conferences were held on 01/22/25, 04/15/25, 07/14/25, and 10/27/25. Further review of the medical record revealed the care conferences held on 01/22/25 and 04/15/25 were created on 06/16/25 and completed on 06/16/25, the care conference dated 07/14/25 was created on 01/05/26 and completed on 01/05/26, and the care conference dated 10/27/25 was created on 01/05/26 and completed on 01/06/26. Interview on 01/07/26 at 3:15 P.M., Social Worker (SW) #314 verified the care conferences were not documented timely. SW #314 stated she had gotten behind on documentation. Interview on 01/07/26 at 3:16 P.M., the Director of Nursing (DON) also verified the care conferences were not documented in the medical record in a timely manner.		