STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366393	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein at Maineville	201 Marge Schott Way Maineville, OH 45039

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on observation, medical record review, staff interview and policy review, the facility failed to ensure residents were provided with dignity and respect. This affected one (#51) of three residents reviewed for dignity and respect. The census was 55. Findings include: Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included dementia and atrial fibrillation. Review of the care plan dated 08/29/24 for Resident #51 revealed the resident displayed behaviors of feeling insecure in the environment and sometimes with care and yelling out for help. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was moderately cognitively impaired. Observations of Resident #51 on 11/05/24 from 11:00 A.M. to 11:40 A.M. revealed the resident was in her room seated in a recliner and yelling out for help. Certified Nursing Assistant (CNA) #109 was observed in the common area. During this time, CNA #109 was observed sitting at the counter by the kitchen and was getting some residents up in the common area to a wheelchair to go out for lunch and able to hear the resident. The resident continued yelling help me and hurry. At 11:40 A.M. CNA #109 went into the resident's room and told the resident she would be right back. CNA #109 went to the kitchen got a can of soda for the resident and took it to her. The resident stopped yelling out. Interview with CNA #51 on 11/05/24 at 11:51 A.M. revealed Resident #51 had behaviors of yelling out. CNA #51 verified resident was yelling out for help for 40 minutes, prior to her checking on the resident. Review of the policy entitled Resident Rights dated 01/22/20 revealed the residents have the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. This deficiency represents non-compliance investigated under Complaint Number OH00158944 and OH00158592.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, policy review and staff interview the facility failed to ensure consecutive documentation of no urine output from an indwelling catheter was reported to the physician. This affected one (#01) of three reviewed for urine output. The facility identified four residents with indwelling catheters in the facility. The facility census was 55. Findings included: Review of medical record Resident #01 revealed an admitted [DATE]. Medical diagnoses included obstructive and reflux uropathy, non-Alzheimer's dementia, malnutrition, and complete uterovaginal prolapse. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was severely cognitively impaired. Review of the physician order for Resident #01 dated 08/01/24 revealed the resident was to have the urine output measured every shift. Review of the Certified Nursing Assistant (CNA) tasks documentation for Resident #01 revealed on 08/22/24 there was no urine output recorded for first shift (7:00 A.M. to 3:00 P.M.) and second shift (3:00 P.M. to 11:00 P.M.). On 08/23/24 there was no urine output recorded for first, second or third shift (11:00 P.M. to 7:00 A.M.). On 08/24/24 and 08/25/24 there was no urine output recorded on night shift. On 08/26/24 there was nothing recorded for day shift and night shift. On 08/28/24 there was urine output recorded on day shift. Review of the nurse's progress note for Resident #01 from 08/22/24 through 08/26/24, revealed no documented evidence that the physician was notified when the resident had no recorded urine output for the days and times listed. Review of a nurse's progress note dated 08/29/24 at 7:00 A.M., revealed Registered Nurse (RN) #77 was informed by a CNA, Resident #01 did not have any urine output for Resident #01 during the last couple of nights. There was no documented evidence that the physician was notified. Review of policy entitled Notification of Change of Condition dated 11/22/21 revealed the facility will immediately inform the resident; consult with the resident's physician, nurse practitioner or clinical nurse specialist; and if known, notify the resident's representative when there is an accident involving the resident, which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e. , a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH 00158944 and OH00158592.

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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** 34291 Based on observation, medical record review and staff interviews, the facility failed to ensure gloves were used in a sanitary manner to prevent infection. This affected one (#04) of three residents reviewed for indwelling catheters. The facility identified there were four residents with catheters in the facility. The census was 55. Findings included: Review of medical record for Resident #04 revealed an admitted [DATE]. Medical diagnoses included hypertension and neurogenic bladder. Resident #04 was active with hospice services. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #04 was severely cognitively impaired and had an indwelling catheter. Review of the care plan dated 09/05/24 revealed Resident #04 had an indwelling catheter and was on enhanced barrier precautions (EBP). Interventions were for staff to wear gown and gloves for high-contact resident care. During observation of catheter care for Resident #04 on 11/06/24 at 1:36 P.M. revealed Certified Nursing Assistant (CNA) #102 came into the resident's room washed her hands, put on a blue isolation gown and placed gloves on her hands. CNA #102 got a basin and went into the bathroom and filled it with water. CNA #102 used her gloved right hand to lower the head of the bed with the remote, removed the bed covers from the resident, unfastened the resident's incontinent brief, and covered the top of the resident with a blanket. CNA #102 used both gloved hands and was pushing the urine down the drainage line into the catheter bag. CNA #102 put a washcloth into the water, added soap and washed the resident's peri area. CNA #102 finished and opened the trash can lid with her right gloved hand and placed the washcloth into it. CNA #102 used a clean towel and dried the resident, opened the trash can with her right hand and discarded the towel CNA #102 retrieved another cloth from the basin, using her contaminated gloved hands and wiped the catheter tubing near the insertion area. CNA #102 placed a blanket on top of the resident, removed her gloves and completed hand hygiene. During an interview with CNA #102 #102 on 11/06/24 at 2:00 P.M. verified she placed gloves on and proceeded to touch the numerous aforementioned items in the room before completing catheter care on Resident #04. CNA #102 verified she used her contaminated gloves to perform catheter care and did not complete any hand hygiene during the process. Review of the policy entitled Indwelling Urinary Catheter (Foley) Care and Management undated, revealed the following: a. Gather and prepare the equipment and supplies. Perform hand hygiene. b. Confirm the patient's identity and provide privacy. c. Explain the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Make sure you have adequate lighting. e. Review the necessity of continued catheter use. Raise the bed to waist level. f. Perform hand hygiene. g. Put on gloves and necessary personal protective equipment. Inspect the catheter system for problems; replace it if necessary. h. Provide routine hygiene for meatal care. Clean the periurethral area using soap and water (or a perineal cleaner, if used in your facility) or a plain disposable wipe. i. Inspect the periurethral area for signs of inflammation and infection. Make sure that the catheter is secured properly. j. Assess the securement device daily and change it when clinically indicated. Monitor intake and output, as ordered. Monitor for changes in urine output. k. Empty the drainage bag regularly when it becomes one-half to two-thirds full. Use a separate collecting container for each patient, avoid splashing, and don't allow the drainage spigot to come in contact with the nonsterile collecting container. l. Keep the drainage tubing free from kinks and avoid dependent loops. m. Keep the drainage bag below the level of the patient's bladder but off of the floor. n. Return the bed to the lowest position. o. Discard used supplies in appropriate receptacles. p. Remove and discard your gloves and, if worn, other personal protective equipment. q. Perform hand hygiene. Document the procedure. This deficiency represents non-compliance investigated under Complaint Numbers OH00158944 and OH00158592.