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	05/16/2025

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 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. THIS IS AN INCIDENCE OF PAST NON COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interviews, observation, and policy review, the facility failed to ensure portable space heaters were not utilized in resident rooms in when the facility Heating, Ventilation, and Air Conditioning (HVAC) system malfunctioned causing the temperatures in House 150 to drop. This affected five (Rooms #106, #107, #108, #109, and #110) of 12 resident rooms in House 150. The facility has five separate houses. Findings include: During an interview on 05/06/25 at 9:04 A.M., MC #404 found that the heat malfunctioned in a section of House 150 on or about 04/17/25. MC #404 stated he was not sure when the heat malfunctioned. The affected resident rooms were Rooms #106, #107, #108, #109, and #110. MC #404 stated that he was unable to fix the heat immediately and portable space heaters were placed in resident Rooms #106, #107, #108, and #110. MC #404 stated that he did not know where the portable space heaters came from, who placed them in the resident rooms, or what happened to the space heaters. MC #404 stated that he did take temperatures of the rooms while the heat was out but did not have any documentation and that the lowest temperature, he could remember was 67 degrees F. MC #404 was not sure in which room he noted that temperature. During an interview on 05/06/25 at 9:28 A.M., MND #555 stated the heat went out on 04/16/25 resulting from a bad gas valve in House #150. MND #555 stated that the heat was fixed on 04/22/25 by the facility ' s heating contractor. Review of the facility policy titled Loss of Heat from emergency preparedness, dated 10/29/2017, revealed the policy was to provide comfortable and safe temperature levels. The temperature throughout this facility shall be maintained at between 71-81 degrees to avoid potential negative impact degrees. Any temperature outside of this rage requires specific interventions to avoid potential negative impact on the residents' well-being. Should the air conditioning or heating system fail, specific monitoring and safety measures should be activated. Environmental temperatures are monitored by staff. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Space Heaters dated 05/05/25 revealed that life safety code by the National Fire Protection Association generally prohibits the use of portable space heaters in healthcare occupancies such as nursing homes. According to the NFPA 101 portable space heaters are not allowed in any residents' sleeping room or compartments. Portable space heaters can overload a facility's electrical system. In addition, space heaters can become a tripping hazard or be covered with combustible materials such as sheets, blankets, or pillows, which may result in a fire. The facility prohibits the use of any portable space heater in the facility. If the portable space heaters were found the employee would be subject to disciplinary action or termination. The deficient practice was corrected on 05/04/25 when the facility implemented the following corrective actions: • On 04/18/25, the Administrator began educating all employees that space heaters are not permitted in resident rooms, and if found, to notify the Administrator as soon as possible. All immediate education was given in person to employees working at the time during second shift 04/18/25, including Leadership/Interdisciplinary Team (IDT) employees with messages and/or calls going out to others. All employees were notified by the Administrator that they must complete and acknowledge education as soon as possible, but that it was mandatory before the next shift worked. • On 04/18/25, Maintenance Coordinator (MC) 404 was educated by the MND #555 with regard to the prohibition of use of space heaters in nursing areas. • A Quality Assurance and Performance Improvement (QAPI) meeting was held on 04/18/25 at 4:30 P.M. The Medical Director was in attendance by telephone and was in agreement with the plan of action. The IDT was present as well or called in by telephone, including MC #404. • Beginning 04/17/25, every day/every shift/every house/every room will have twice a shift per day have audits to be completed on room temperatures and to ensure no space heater is present. The nurse on duty or designee will complete the audit to verify that no space heaters are present, and room temperatures are between 71-81 degrees Fahrenheit (F) and residents are comfortable. The employee who was designated will review the audits in real time to verify accuracy and any need to make immediate corrections. Audits to be completed at this pace and interval until 04/27/25. From 04/28/25 on, the same audits will occur once daily in all rooms and all houses for two weeks and then weekly for two weeks. Audits, along with the rest of this action plan, will be reviewed by the QAPI committee and recommendations about amendments to the plan, audit scope or frequency, or other feedback will be shared. • (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility audits dated 04/17/15 through 05/04/25 revealed audits were performed twice a shift daily. • During interviews on 05/07/25 from 1:27 P.M. through 2:34 P.M., Licensed Practical Nurse (LPN) #313 and Certified Nursing Assistants (CNA) #314, #298, #255, #412, and #331 all stated they had received education about space heaters not being allowed at the facility, and to notify management of temperatures of resident rooms not in range of 71 degrees to 81 degrees. Staff was also educated on telling families not to bring in space heaters. This deficiency represents non-compliance investigated under Master Complaint Number OH0015344 and Complaint Number OH00165076.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 record review, observation, staff and physician interview, review of hospital records, and policy review, the facility failed to ensure the residents environment remained as free from accident hazards as possible when the Heating, Ventilation, and Air Conditioning (HVAC) system malfunctioned causing the temperatures in House 150 to drop, and portable space heaters were placed in four resident rooms, which were prohibited. This resulted in Immediate Jeopardy and serious life-threatening physical harm and/or injuries when on 04/17/25, Resident #47 sustained a full thickness burn to the left outer calf from below the knee to the top of the left foot. Resident #47 was sent to the hospital to be evaluated on 04/25/25 and required hospitalization due to the severe burns that developed faecalis and Enterococcus (E.) faecium infection in the wounds. This affected one (Resident #47) of four residents reviewed for accident hazards and placed an additional three residents (#04, #49 and #51) at risk for potential serious physical harm and/or injuries who had space heaters placed in their rooms in House 150. On 05/07/25 at 3:35 P.M., the Administrator, Director of Nursing (DON), Clinical Regional Nurse (CRN) #399, Regional Administrator (RA) #477, and Maintenance Neighborhood Director (MND) #555 were notified the Immediate Jeopardy began on 04/17/25 at 3:00 P.M. when Resident #47 sustained severe burns to his left leg from below his knee outer to the top of his left foot as a result of the use of a portable space heater in the resident's room. A treatment of Silvadene (a topical antibiotic used in partial thickness and full thickness burns was used to prevent infection) was implemented on 04/18/25 when Wound Physician (WP) #449 saw and examined Resident #47. Resident #47 was seen again on 04/25/25 by WP #449 and Wound Nurse (WN) #509 who had noticed the change in the left leg, and the left foot had three black toes from the middle toe to pinkie toe. WP #449 recommend that Resident #47 go to the emergency room to be evaluated. Resident #47 was admitted to a hospital Intensive Care Step Down Unit with burns to left leg and foot, urinary tract infection, and pneumonia in both lungs. Resident #47 was started on intravenous antibiotics immediately due to infection, cellulitis, and burns. Resident #47 was discharged from the hospital to another nursing home on [DATE]. Resident #47 was currently being treated at the burn unit clinic at the hospital as an outpatient. Although the Immediate Jeopardy was removed on 04/17/25 when WN #509 removed the portable space heaters from the rooms of Residents #04, #47, #49 and #51, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on 05/04/25 when the facility implemented the following corrective actions: • On 04/18/25, the Administrator began educating all employees that space heaters are not permitted in resident rooms, and if found, to notify the Administrator as soon as possible. All immediate education was given in person to employees working at the time during second shift 04/18/25, including Leadership/Interdisciplinary Team (IDT) employees with messages and/or calls going out to others. All employees were notified by the Administrator that they must complete and acknowledge education as soon as possible, but that it was mandatory before the next shift worked. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	• On 04/18/25, Maintenance Coordinator (MC) #404 was educated by MND #555 with regard to the prohibition of use of space heaters in nursing areas. • A Quality Assurance and Performance Improvement (QAPI) meeting was held on 04/18/25 at 4:30 P.M. The Medical Director was in attendance by telephone and was in agreement with the plan of action. The IDT was present as well or called in by telephone, including MC #404. • Beginning 04/17/25, every day/every shift/every house/every room will have twice a shift per day audits to be completed on room temperatures and to ensure no space heater is present. The nurse on duty or designee will complete the audit to verify that no space heaters are present, and room temperatures are between 71-81 degrees Fahrenheit (F) and residents are comfortable. The employee who was designated will review the audits in real time to verify accuracy and any need to make immediate corrections. Audits to be completed at this pace and interval until 04/27/25. From 04/28/25 on, the same audits will occur once daily in all rooms and all houses for two weeks and then weekly for two weeks. Audits, along with the rest of this action plan, will be reviewed by the QAPI committee and recommendations about amendments to the plan, audit scope or frequency, or other feedback will be shared. • Review of facility audits dated 04/17/15 through 05/04/25 revealed audits were performed twice a shift daily. • During interviews on 05/07/25 from 1:27 P.M. through 2:34 P.M., Licensed Practical Nurse (LPN) #313 and Certified Nursing Assistants (CNA) #314, #298, #255, #412, and #331 all stated they had received education about space heaters not being allowed at the facility, and to notify management of temperatures of resident rooms not in range of 71 degrees to 81 degrees. Staff was also educated on telling families not to bring in space heaters. Findings include: Record review revealed Resident #47 was admitted on [DATE]. Review of the hospital Discharge summary dated [DATE] revealed Resident #47 had spinal cord compression recently due to epidural hematoma and had lower extremity paralysis. Additional diagnoses included diabetes mellitus. Review of the progress note dated 04/17/25 at 7:52 P.M. revealed the DON documented LPN #205 was notified by CNA #355 that Resident #47 had increased edema with weeping fluids from both legs. During the assessment, Resident #47 was noted with weeping edema. Resident #47 stated he was not currently experiencing any pain. Resident #47's lower extremities were cleansed with normal saline and patted dry. Abdominal (ABD) pads and Kerlix were placed on his legs. Resident #47 was his own person, and his family member was visiting in the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a progress note dated 04/17/25 at 11:56 P.M. revealed the DON documented Resident #47's lower extremities were reassessed and had a superficial open area to the left lower leg. A new treatment of Xeroform gauze was initiated and put in place. Resident #47 had ABD pads on his leg. The physician was notified. Review of the initial wound evaluation and management summary dated 04/18/25 revealed WP #449 documented Resident #47 had wounds on his left lateral ankle and left lateral leg. History of the present illness was a space heater burn on left leg. The burn wound of the left lateral ankle was full thickness that measured 7 centimeters (cm) by 6 cm by 0.1 cm. Slough was 30 percent, granulation tissue was 70 percent. No signs of infection. WP #449 debrided the left ankle by removing the necrotic tissue and establishing the margins of viable tissue. The burn wound of the left lateral leg was full thickness and measured 20 cm by 10 cm by 0.2 cm that had 100 percent granulation tissue. No signs of infection. Review of the service order from the HVAC contractor, dated 04/18/25, revealed a service call was made to troubleshoot heating operations in House 150. The hot surface igniter did not come on initially. After cycling power, the hot surface igniter came on, but the gas did not ignite. As a result of intermittent issues, it was recommended to replace the control board, pressure switch and gas valve. Gas valve and pressure switch on order. Review of a service order from the HVAC contractor, dated 04/22/25, noted the faulty gas valve, control board and pressure switch were replaced in House 150. The heating unit was operational. Review of a wound evaluation dated 04/25/25 by WP #449 revealed Resident #47 had been seen today for wounds to his left lateral leg, right lower lateral leg, sacrum, and right buttocks. History of present illness stated space heater burn on the left leg. The left lateral leg was a full thickness burn and measured 19.5 cm by 7.0 cm by 0.2 cm. Exudate was light, thick adherent devitalized necrotic tissue 50 percent, slough 30 percent, granulation tissue 20 percent, and no signs of infection. A surgical excisional debridement procedure was done to remove necrotic tissue to establish the margins of viable tissue. The left distal foot was described as a full thickness venous wound measuring 3.5 cm by 7.0 cm by 0.2 cm. Exudate light serous fluid, granulation tissue 100 percent. No signs of infection. Review of the hospital Discharge summary dated [DATE] revealed that Resident #47 had admitting diagnoses of urinary tract infection with foley catheter, bilateral pneumonia, and infected left lower extremity, sacral ulcer, and atrial fibrillation (A-fib). Resident #47 had a history of A-fib, diabetes, hypertension, paraplegia secondary to cord compression (03/13/25), neurogenic bladder who presented with cellulitis of left lower extremity/burn injury. He had sustained a burn wound to his left lower extremity from a space heater that was next to his leg. Resident #47 was paraplegic with decreased sensation from his torso down. He was also found to have possible pneumonia as well as urinary tract infection. Left lower extremity cellulitis and burn had wound culture that found faecalis, and E. faecium. Resident #47 on Vancomycin (a powerful antibiotic used to treat a range of serious bacterial infections) while an inpatient. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/05/25 at 1:06 P.M., MC #404 stated that the facility had heating problems on 04/17/25 in House 150. Resident rooms were not heated above 71 degrees Fahrenheit (F). MC #404 stated Rooms #106 through #110 had problems with heating. MC #404 looked at the unit, and observed it was working, then not working. He called the HVAC company that came out the next day to determine the problem. On 04/18/25 there were problems with the gas valve for that side of the building. The pressure switch was not opening, and the circuit board was failing. MC #404 stated that he checked the room temperatures. He couldn ' t remember what the temperatures were and did not document them, but he knew they were below 71 degrees F. MC #404 stated he had never given space heaters to any residents. MC #404 stated the facility had no space heaters. MC #404 stated he did not know there were space heaters in the rooms at the facility or where they came from. MC #404 stated the reasons not to have a space heater were the risk of starting a fire or a resident getting burned. During an interview on 05/05/25 at 2:56 P.M., LPN #205 stated that CNA #355 had told her that Resident #47 was sitting too close to the space heater. LPN #205 stated when assessing Resident #47, he had large amounts of clear fluid draining from his left leg. LPN #205 stated she notified the management and wrapped his legs with Kerlix right away when he was lying down in his bed. During an interview on 05/05/25 at 3:11 P.M., CNA #270 stated she worked first shift on 04/17/25. When she returned to work on 04/18/25, Resident #47 had a burn on his left calf that was red with bubbles like blisters. On 04/18/25 there was a physician that came in to see Resident #47. Resident #47 had a bubble on his left ankle, and on the top of his left foot. WP #449 popped the bubble on his left ankle. Resident #47 had other bubbles on his left leg. Resident #47's skin to the left leg was also leaking fluid. CNA #270 stated that on 04/17/25, Resident #51 and Resident #49 also had space heaters. CNA #270 stated that the space heater did get hot to touch and could cause a burn. CNA #270 said the Administrator was aware, because she was the one that told them to move the space heaters into the rooms of Residents #49 and #51. CNA #270 said the heat was broken for a week and the temperature in the building was in the 70's. During an interview on 05/05/25 at 4:11 P.M., Resident #49 stated when she arrived at the facility on 04/07/25 she had complained about the heat that day. Resident #49 stated the thermostat kept reading 78 degrees F, and the room was not that warm. She stated that MC #404 had come to see her room and told her that the heater was broken. Resident #49 stated she watches the weather, and there was a frost warning that day. Resident #49 stated she had no heat for eight days. She said she received a space heater on 04/17/25 but was afraid to turn it on. Resident #49 stated that once the resident got burnt the facility then pulled the space heaters and moved residents into other rooms. During an interview on 05/05/25 at 4:24 P.M., CNA #255 stated the heat went out the week of 04/17/25. CNA #255 stated that Resident #47 was up in his wheelchair because therapy got him up. Resident #47 stated he was cold, and he was given a blanket to use in his wheelchair. MC #404 had brought a space heater to Resident #47's room. CNA #255 stated the space heater was under the television at the foot of the bed. The space heater was on and was heating his room. CNA #255 stated that she had seen pictures of the resident's leg, and it was red, blistered, and skin peeling off. CNA #255 stated the only residents she knew of that had a space heater in their room were Residents #49 and #51. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/05/25 at 4:26 P.M., Resident #47's family member stated when he entered the room on 04/17/25 at 6:40 P.M. he saw Resident #47 sitting less than six inches from a space heater. He pulled Resident #47's wheelchair back away from the space heater. The family member notified staff to put Resident #47 back to bed and told the staff to check his legs because he saw something. Resident #47's legs were blistering, and liquid was pouring out of them during the lift transfer to bed. After Resident #47 was laid down in bed, the bed linens were soaking up liquids from his legs. He had redness on the left leg, blisters and peeling skin. Resident #47's family member said it looked like a burn on his left leg. During an interview 05/06/25 at 9:28 A.M., WP #449 stated he talked to the nurse practitioner prior to seeing Resident #47 on 04/21/25. He and the nurse practitioner decided to call the wounds on the resident's legs venous ulcers. WP #449 stated he had seen Resident #47 and was concerned about his wounds on his left leg. WP #449 requested Resident #47 to be sent to the hospital because of the black toes on the left foot. On 04/18/25 there were no black toes and on 04/25/25, he told the Administrator and DON to send him to the hospital, to have an evaluation. WP #449 stated this was the best course of action for Resident #47 because his wounds got worse. During an interview on 05/06/25 at 9:48 A.M., Resident #47's family member stated he was currently being seen at a burn clinic for treatment. During an interview on 05/06/25 at 10:38 A.M., CNA #355 stated she had reported for work on 04/17/25 at 3:00 P.M. CNA #355 stated that when she got to work, she noticed portable space heaters in resident rooms and stated she was confused because she was told they are not allowed to have them. The portable space heaters were in resident Rooms #106, #108, and #110. She was told by another staff that the heat had gone out on 04/14/25. CNA #355 stated that around 5:00 P.M. she started cooking for the residents. At around 6:00 P.M., she went into resident room [ROOM NUMBER] and observed Resident #47 in his wheelchair about a foot away from a portable space heater. She moved Resident #47 away from the space heater to the other side of the room and advised him that it was not safe to be that close to the portable space heater due to him not having any feeling in his legs. At 6:40 P.M., CNA #355 stated that she was paged to resident room [ROOM NUMBER] and when she went to the room Resident #47 was again up too close to the portable space heater. She asked him if he wanted to come out for dinner and he replied he did not. At this time, Resident #47 asked to be placed into his bed. CNA #355 stated that as she was transferring Resident #47 at 7:00 P.M. to his bed, she noted that his leg was red and hot to the touch. She placed Resident #47 into a Hoyer lift and as he was about halfway up to the bed, his leg busted open and began spraying fluid. LPN #205 was called and came into evaluate Resident #47's injuries. LPN #205 examined his leg at 7:25 P.M. and then wrapped it. CNA #355 stated that she attempted to call the Administrator and the DON but got no answer. She then contacted Coach #444 and reported the incident to her. CNA #355 stated that she returned to the room and noted that the leg was leaking a lot of fluid and that the skin was peeling back and the area affected was on his left leg from his toes to his knee. CNA #355 stated that she received a call from both the Administrator and the DON who advised her to remove the portable space heaters and transfer residents to other rooms. Resident #47 did not want to move rooms at this time. CNA #355 stated that WN #509 removed the space heaters, and she did not know where they were placed. CNA #355 stated that she did not know the make and model of the portable space heaters, but it was not the first time the facility had used portable space heaters. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/06/25 at 11:00 A.M., the DON stated that Resident #47 did not have any black toes when he was at the facility. She was unaware that the wound physician was concerned about Resident #47's black toes. During an interview on 05/06/25 at 11:05 A.M., the Administrator stated that the facility had heat problems in House 150. The facility never had space heaters, and none at this time. The Administrator stated the employees at the facility had put the space heaters out in resident rooms. She did not know where the space heaters came from. She stated she was not aware that Resident #47 had a burn. There were five rooms affected by the heat that was not working. During an interview on 05/06/25 at 1:58 P.M., WN #509 stated that she was not there when Resident #47 had an incident with the space heater. She came in on second shift on 04/17/25 at 7:00 P.M. and got the nurse report, and was notified that there was concern for Resident #47's legs. WN #509 stated she removed four space heaters from resident rooms and placed them in the DON's office as directed. Review of the facility policy titled Loss of Heat, dated 10/29/2017, revealed the policy was to provide comfortable and safe temperature levels. The temperature throughout this facility shall be maintained at between 71-81 degrees to avoid potential negative impact degrees. Any temperature outside of this rage requires specific interventions to avoid potential negative impact on the residents ' well-being. Should the air conditioning or heating system fail, specific monitoring and safety measures should be activated. Environmental temperatures are monitored by staff. This deficiency represents non-compliance investigated under Complaint Numbers OH00165344 and OH00165076.