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	12/16/2025

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 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (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 0805 Level of Harm - 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, review of facility Self-Reported Incidents (SRIs), staff interview, and policy review, the facility failed to provide a resident's food in the correct texture to meet individual needs per physician's orders for one (Resident #1) resident. This resulted in actual harm when Resident #1 choked on the food of incorrect texture which caused the need for cardiopulmonary Resuscitation (CPR) and hospitalization. This affected one (Resident #1) of three residents reviewed for specialized diets. The facility census was 50. Findings include: Record review revealed Resident #1 was originally admitted to the facility on [DATE] with diagnoses including type 1 diabetes, chronic obstructive pulmonary disease, dementia, personal history of transient ischemic attack, cerebral infarction, gastro-esophageal reflux disease, and anxiety disorder. Review of Resident #1's Minimum Data Set (MDS) significant change assessment, dated 12/09/25, revealed he was cognitively intact. He required supervision with eating and was dependent on activities of daily living (ADL). Review of the Care Plan for Resident #1 dated 12/09/25 revealed he was at risk for changes to nutrition due to risk of aspiration related to dysphagia. Interventions included providing his diet as ordered, monitoring for signs of aspiration and referral to speech therapy as needed. Review of the physician orders on 12/04/25 revealed Resident #1 was ordered a regular diet with minced and moist texture. Review of a nursing progress note for Resident #1 dated 12/04/25 revealed an unidentified Certified Nursing Assistant (CNA) #125 yelled from Resident #1's room that the resident was blue and not breathing. A nurse ran to assist, and no visible breathing was noted. The nurse instructed the staff to call for additional assistance and to call 911. Resident #1 was lowered to the floor and found to be choking on food. Some breath was noted while he was tongue thrusting to remove food. He was able to dislodge some food, and more was dislodged with a mouth sweep. Cardiopulmonary resuscitation (CPR) was initiated when no pulse was found and continued until emergency services personnel (EMS) arrived and took over. EMS reported Resident #1 had a pulse when they left the facility. Review of an additional progress note dated 12/04/25 revealed the nurse called the hospital for an update and was notified Resident #1 had been intubated and would be admitted . Review of the Self-Reported Incident (SRI) dated 12/05/25 revealed Resident #1 was found unresponsive in his room on 12/04/25 at approximately 6:00 P.M. CPR was immediately started and 911 was called. Food was noted in Resident #1's mouth during resuscitation measures. During the investigation it was noted Resident #1 generally ate in his room and had an order for a minced and moist diet which he was able to consume with intermittent supervision from staff. Social Worker (SW) #303, who normally would not prepare or serve meals provided a plate without checking Resident #1's diet order. She provided a regular texture meal. Approximately six minutes after receiving the wrong diet order, a CNA #125 walked into the room with a plate containing the correct diet and found Resident #1 unresponsive. CNA #125 immediately called for assistance with CPR initiated and 911 called. He was subsequently transferred to the hospital. The facility took corrective actions but did not substantiate neglect. Review of the hospital discharge paperwork for Resident #1 dated 12/09/25 revealed he was admitted from 12/04/25 through 12/09/25 with a diagnosis of cardiac arrest and pneumonitis to due inhalation of food and vomit. He was released with a diet order of a regular diet with pureed texture and moderately thick liquids. During an interview on 12/15/25 at 1:30 P.M., the Administrator and Director of Nursing (DON) confirmed all staff were trained on 11/20/25 verifying diet orders prior to serving meals in anticipation of the upcoming holiday dinner. On 12/04/25 the facility had a holiday dinner which included turkey and mashed potatoes. SW #303 heard staff state Resident #1 had not yet received a plate and she thought he would enjoy the garlic mashed potatoes, so she made him a plate and provided it without checking his diet order. About two minutes later she brought him a napkin and he was fine. About six minutes later an aide brought the correct diet to him not knowing he had been provided the wrong diet and found him unresponsive. She called for the nurse who began CPR and he was sent out to the hospital where he was on a ventilator in the intensive care unit (ICU) a couple of days and then returned to the facility with his diet downgraded to pureed. There were no other residents provided the wrong diet texture during this holiday meal on 12/04/25. During an interview on 12/15/25 at 3:38 P.M., Registered Nurse (RN) #168 stated revealed they were having a holiday dinner, and the social worker was assisting with ensuring all residents received a meal so she brought Resident #1 a plate of food without checking his diet order. A few