STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, staff interview and facility policy and procedure review, the facility failed to follow physician orders for obtaining weekly weights to monitor weight gain related to congestive heart failure. This affected one resident (#29) of five resident record reviews. The census was 56. Findings included: Review of Resident #29's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, diabetes, atrial fibrillation, left above knee amputation, morbid obesity, non pressure ulcer of the left leg, lymphedema, chronic kidney disease and absence of right toes. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed her cognition was intact. She was independent with eating, required set up or clean up assistance with oral hygiene, substantial/maximal assistance with toileting, partial/moderate assistance for bathing/showering, and personal hygiene and supervision/touching assistance for turning and repositioning. She was dependent on staff for sit/to stand, chair to bed, toilet transfer, and tub/shower transfer. The resident was occasionally incontinent of bowel and frequently incontinent of urine. Review of the physician orders revealed an order dated 01/19/25 to check the resident's weight weekly and notify physician if weight was up five pounds in one week. The resident was to be weighed one time a day every seven days for congestive heart failure, weight gain. Further record review revealed documented weights of 01/21/25 at 256 pounds (lbs), 02/01/25 at 256.4 lbs, 02/19/25 at 256.4 lbs, 03/12/25 at 267 lbs, 03/18/25 at 267 lbs, 04/03/25 at 265.2 lbs and 4/10/2025 at 265.5 lbs. Interview on 05/13/25 at 10:00 A.M. with the Director of Nursing verified weekly weights had not been obtained according to physician orders. Review of the undated facility policy and procedure Weights if weekly weights are requested, they will be done on a daily basis or weekly based on the day the initial weight was obtained. This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number OH00165495.

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
	366424	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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 - Actual harm Residents Affected - Few	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** 19571 Based on record review, review of self reported incidents (SRI), interview, and policy and procedure review, the facility failed to ensure residents received appropriate assistance with transfers and failed to ensure a sit to stand lift was used appropriately during a transfer. This affected two residents (#29 and #58) of five residents reviewed. The census was 56. Actual physical harm occurred to Resident #29 on 04/15/25 when staff failed to have the sling to the sit to stand lift applied appropriately under the resident during a transfer and the resident sustained bruising, a hematoma, fractured ribs resulting in the resident being transferred and admitted to the hospital with diagnoses of hematoma, bruising, rib fractures, and anemia from blood loss. The resident complained of increased pain as a result of the incident and was hospitalized for seven days for treatment following the incident. Actual physical harm occurred to Resident #58 on 02/22/25 when a Certified Nursing Assistant (CNA), without the use of a gait belt, assisted the resident to ambulate to the bathroom, the resident started to fall and the CNA grabbed the resident and held the resident up by the resident's arms causing a dislocated shoulder as the resident was laid on the ground. The resident was transferred and admitted to the hospital with a diagnosis of a dislocated right shoulder with surgery recommendation for repair. Findings include: 1. Review of Resident #29's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, diabetes, atrial fibrillation, left above knee amputation, morbid obesity, non pressure ulcer of the left leg, lymphedema, chronic kidney disease and absence of right toes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29's cognition was intact. The assessment revealed the resident was independent with eating, required (staff) set up or clean up assistance with oral hygiene, substantial/maximal staff assistance with toileting, partial/moderate staff assistance for bathing/showering, and personal hygiene and staff supervision/touching assistance for turning and repositioning. She was dependent on staff for sit/to stand, chair to bed, toilet transfer, and tub/shower transfer. The resident was occasionally incontinent of bowel and frequently incontinent of urine. Review of Resident #29's Functional Abilities assessment dated [DATE] revealed the resident was dependent on staff for toileting hygiene, shower/bathing, dressing, personal hygiene, turning and repositioning, sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident #29 was non-ambulatory. Review of the nursing note dated 04/19/25 at 8:20 P.M. revealed Resident #29 complained of pain around arm pit and axillary area, when checked, bruising and swelling was noted. The physician was notified and ordered ICE and massaging the area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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 - Actual harm Residents Affected - Few	Review of the facility investigation dated 04/20/25 revealed Resident #29 reported discomfort and pain on her left arm pit, when the resident was assessed and the nurse inspected the area, the nurse identified a hardened purplish bruise. When the resident was asked what had happened she revealed she had gotten the bruise from the sit to stand sling when she was going to bed on 04/15/25. She had not reported pain or discomfort at the time of the incident when asked if she felt pain when it happened. The area measured 11 centimeters (cm) by six cm. The resident's physician was notified and ordered no sling uses until re-evaluation, ICE (Rest, Ice, Elevation and Massage). Review of the nursing note dated 04/21/25 at 6:18 P.M. revealed the resident was seen by the physician. A new order was received to hold Eliquis (oral anticoagulant medication) four doses due to bruising around the arm pit and axillary area and prednisone (steroid) 30 milligrams (mg) everyday for three days then back to 10 mg everyday. The nursing note revealed bruising was persistent and monitoring to occur every shift, no bleeding noted, area intact. When needed pain medications given as ordered. Review of the nursing note dated 04/23/25 at 4:48 P.M. revealed the resident complained of not feeling well, dizziness, weakness, no void (urine output) since midnight. Resident #29 requested to be sent to the hospital and was admitted for bruising, anemia (requiring blood transfusion) and rib fractures. On 05/12/25 at 12:42 P.M. interview with Resident #29 revealed the aide used the sit to stand lift (on 04/15/25) to put her to bed and the sling that goes around her was twisted. The resident indicated she had no pain (at first) but the next day as the day wore on it became more painful, then the next day it was quite painful. They finally sent the resident out and her hemoglobin was a six (6), the resident had a huge hematoma, bruising under her arm and fractured ribs. The resident was admitted and received three units of blood. Further interview with Resident #29 on 05/13/25 at 9:35 A.M. revealed she was transferred on 04/15/25 with the sit to stand lift by one CNA. The resident stated that's what they did all the time with the sit to stand lift. Review of the Hospital After Summary Visit form revealed Resident #29 was hospitalized from 04/24/25 to 05/01/25. On 05/12/25 at 2:24 P.M. interview with the Assistant Administrator revealed on 04/15/25, one CNA was operating the sit to stand lift to transfer Resident #29. The CNA no longer worked at the facility as of this date. Per the Assistant Administrator, CNA #128 was trained on the proper use of the sit to stand lift after the incident was brought to the facility's attention. 2. Record review revealed Resident #58 was admitted to the facility on [DATE] with diagnoses that included heart failure, chronic obstructive heart disease, diabetes, depression, and chronic kidney disease (CKD). Review of the admission MDS dated [DATE] revealed Resident #58's cognition was intact. The resident was assessed to be independent with eating, required staff set up or clean up assistance with oral hygiene, toileting, partial moderate staff assistance for showering/bathing, dressing, personal hygiene and turning and repositioning and supervision and touching assistance for transfers. The resident was occasionally incontinent of urine and frequently incontinent of bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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 - Actual harm Residents Affected - Few	Review of the nursing note dated 02/22/25 at 5:54 A.M. revealed Resident #58 was found on the floor laying on her back and her head down, with the walker on top of her, nurse called out her name but the resident was not responding to simple commands at the time. The nurse initiated a breathing treatment, elevated the resident's head and called 911. The nurse stayed with the resident. No visible injuries were noted at the time. The paramedics arrived and took over care of the resident. The resident was transferred to the emergency room for further evaluation. Review of a self reported incident (SRI) form dated 02/25/25 revealed Resident #58 claimed a CNA pushed her on 02/22/25 when getting up to go to the bathroom. Review of the investigation statement form revealed CNA #146 stated it was a fall, per CNA #146 on 02/22/25, Resident #58 was agitated all night and had wet incontinence product on. The resident had her call light on and the CNA told the resident she would change the resident in the bed since her left foot was also swelling and the resident was already incontinent, but the resident became agitated and hoisted herself up. CNA #146 revealed she went to the other side of the bed, fixed the bed and gave the resident the walker. CNA #146 revealed Resident #58 was walking very quickly to the bathroom and she was behind the resident holding onto the walker and the resident was about to fall into the wall of the bathroom and CNA #146 was behind her and laid the resident down on the ground. CNA #146 revealed she did not have a gait belt on Resident #58 when she was assisting the resident to the bathroom, the CNA just laid her down by holding her up under her arms and laying her down. Review of an Orthopedic Surgery Consult Note dated 02/22/25 revealed she was found to have a right shoulder glenohumeral joint dislocation. Provisional reduction was performed in the emergence room, however it was unstable and continued to re-dislocate. There was tentative plans for surgical management, however the resident and family declined surgery. On 05/13/25 at 10:08 A.M. interview with the Administrator verified on 02/22/25 Resident #58 was up with a walker ambulating to the bathroom with the assistance of CNA #146 when the resident was about to fall into the wall so CNA #146 laid the resident down causing the resident to sustain a shoulder dislocation. The Administrator verified CNA #146 did not use a gait belt when assisting Resident #58 to ambulate to the bathroom. Review of the facility policy Use of Gait Belt dated 10/13 revealed the gait belt should be used by the Elder Assistant and/or nurse during every transfer and during ambulation of an elder that requires assistance. This deficiency represents non-compliance investigated under Complaint Number OH00165495.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 19571 Based on observation and staff interview, the facility failed to prepare, distribute and serve food following proper infection control. This had the potential to affect the 12 of 12 residents residing in House 6690. The census was 56. Findings include: On 05/12/25 observations in the kitchen between 11:50 A.M. and 12:16 P.M. revealed Certified Nurse Aide (CNA) #100 washed her hands, put her hair up in a hair net, then put on gloves, gathered baked beans and hot dogs, removed her gloves and put on new gloves without washing her hands. CNA #100 opened the hot dogs and placed them in a pan of water and puts on the stove. She removed her gloves and put on new gloves without washing her hands and opened the baked beans and placed them in a pan. CNA #100 then removed her gloves and washed her hands. At 12:12 P.M. CNA #100 again put on a hair net and then gloves without washing her hands, added brown sugar to the baked beans using her gloves, removed her gloves and her hair net and walked down the hall without washing her hands. At 12:16 P.M. observation revealed CNA #151 washed her hands and put on a hair net and then gloves, gathered silverware and napkins and passed out to the residents, removed gloves and put on new gloves and prepared the drinks. Interview with CNA #100 and CNA #151 on 05/12/25 at 12:50 P.M. verified they had not washed their hands in between glove changes and after putting on their hair nets. This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00165495.