STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366439	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Union Township	1114 Neighborhood Drive Batavia, OH 45103

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 - 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** 41271 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, incident investigation review, and staff interview, the facility failed to provide the appropriate level of assistance during resident transfers. This affected one (Resident #34) of the four residents reviewed for falls. The facility census was 58 residents. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including heart failure and morbid obesity. Review of the plan of care for Resident #34 dated 11/07/23 revealed the resident was at risk for falls related to impaired mobility, history of falls, history of a fractured femur, and obesity. Interventions included to ensure two staff members provided all check and change care. Review of the Minimum Data Set (MDS) assessment for Resident #34 dated 06/19/24 revealed the resident had moderately impaired cognition and required complete staff assistance by two staff members for bed mobility, transfers and most activities of daily living (ADL) care. Review of the progress note for Resident #34 dated 06/04/24 timed at 4:23 A.M. per Registered Nurse (RN) #23 revealed the Elder Assistant (EA) notified the nurse Resident #34 was assisted to the floor while the EA was changing and turning the resident. The nurse assessed the resident and noted multiple bruises to the left forearm. Resident #34 denied pain and neurological checks were within normal limits. The nurse called 911 was called for lift assistance and remained with the resident until emergency personnel arrived to transport the resident to the hospital. Follow up interventions included to ensure the assistance of two staff for all check and changes. Review of the fall investigation form for Resident #34 dated 06/04/24 revealed the resident fell when receiving assistance from one staff member. Resident #34 was assisted to the floor while one staff member was changing and turning resident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigation statement form for Resident #34 dated 06/04/24 per the Director of Nursing (DON) and Hospice RN #836 revealed the hospice RN and the DON assessed the resident's skin following the fall on 06/04/24 and determined there were various areas of discoloration, no bruising noted to shoulder or legs, discoloration noted to left arm that appear to be related to co-morbidities versus actual bruising. Resident #34 had normal range of motion (ROM) to all extremities and denied pain to the joints. Review of the investigation statement form for Resident #34 dated 06/05/24 per the DON revealed RN #23 reported being called to the resident's room by EA #3 who stated she was providing care to the resident and lowered her to the floor from the bed. Review of the investigation statement form for Resident #34 dated 06/05/24 per Elder Assistant Coach (EAC) #585 for an incident that occurred on 06/04/2024 revealed EA #3 stated was providing incontinence care to Resident #34 and she rolled the resident onto her left side and the resident's legs dropped to the side of the bed so the EA put her body against the resident's upper body, used the remote to lower the bed, and then the EA laid the resident onto the floor. EA #3 reported she was the only staff member providing assistance to Resident #34 on 06/04/24 when the resident was lowered to the floor. Review of the witness statement dated 06/05/2024 timed at 11:30 A.M. per EAC #585 revealed the coach educated EA #3 regarding use of the Hoyer lift and the importance of checking the Kardex/care plan on the electronic charting system when coming onto a shift before providing care to elders to ensure the appropriate level of assistance was provided. Interview on 07/24/2024 at 1:00 P.M. with the Administrator confirmed EA #3 lowered Resident #34 to the floor during care. The Administrator further confirmed Resident #34 was care planned to require the assistance of two staff members for bed mobility and incontinence care, and the incident occurred when EA #3 provided bed mobility and incontinence care with only one staff member. The deficient practice was corrected on 06/08/2024 when the facility implemented the following corrective actions: -On 06/04/24 the DON and Hospice RN #836 assessed Resident #34 for injuries and found no fractures or complaints of pain. -On 06/05/24 the DON provided education for all staff on care delivery and review of the Kardex prior to the delivery of care. -On 06/05/24 the Interdisciplinary Team (IDT) reviewed the incident on 06/04/24 involving Resident #34. -On 06/06/24 the DON completed a 72-hour follow up assessment of Resident #34 -On 06/06/24 Resident #34 had an x-ray of her left hip, pelvis, knee, and ankle with no fractures. -On 06/08/24 the DON completed a 100 percent (%) audit of resident care plans to determine that transfers status, bed mobility, and care needs flowed over to their Kardex. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 06/08/24 the DON and/or designee began auditing of transfers for residents including Resident #34 and a random sample of other residents who required the assistance of two staff for bed mobility and transfers. The results would be monitored by Quality Assurance and Performance Improvement (QAPI) committee and frequency would be adjusted per recommendations. Monitoring would continue for four weeks with frequency adjusted as needed by QAPI committee. -Interview on 07/24/2024 from 1:00 P.M. through 2:30 P.M. with Caregiver #326, #338, #565, and #867 confirmed they had received education per management staff on or around 06/05/2024 regarding reviewing each residents Kardex prior to the start of their shift on how to properly deliver their care. This deficiency represents noncompliance investigated under Complaint Number OH00155181.