

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Otterbein Union Township		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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	<p>**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, staff interview, review of self-reported incidents (SRI), review of witness statements, review of personnel files, review of X-ray results, and review of facility policy, the facility failed to ensure Resident #32 was transferred per physician orders and in a manner consistent with her plan of care. This resulted in Actual Harm on 06/22/25 at 4:01 P. M. when Certified Nursing Assistant (CNA) #168 attempted to transfer Resident #32 from the bed to a wheelchair by carrying her without additional staff and without the use of a mechanical Hoyer lift. CNA #168 tripped and fell with Resident #32 and the resident sustained an acute fracture of the right humerus, with mild displacement, and soft tissue swelling. This affected one (Resident #32) of the three residents reviewed for falls. The facility identified 11 additional residents who were dependent on a mechanical lift for transfers. The facility census was 58. Findings include: Review of the medical record for Resident #32 revealed the resident was admitted on [DATE]. Diagnoses included atherosclerotic heart disease, diabetes mellitus (DM), dementia, major depressive disorder, anxiety disorder, essential primary hypertension, and hypoglycemia. Review of a physician order dated 09/03/22 for Resident #32, revealed the resident was ordered to be transferred via mechanical Hoyer lift for all transfers. Review of the Care Plan revised on 02/02/24 for Resident #32, revealed the resident required a mechanical lift for all transfers which required two staff members. The Care Plan was revised on 06/23/35 to include a fall with major injury. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #32, revealed the resident had impaired cognition. Resident #32 was dependent on staff for all activities of daily living (ADLs) including transfers. Review of comprehensive Fall Risk Screening dated 05/15/25 for Resident #32, revealed the resident was at a high risk for falls. Review of the accident/incident log revealed Resident #32 had a witnessed fall on 06/22/25 at 4:00 P.M. Review of a progress note dated 06/22/25 at 4:01 P.M. for Resident #32, revealed CNA #168 transferred Resident #32 to a wheelchair and tripped during the transfer and Resident #32 fell. Resident #32 was lying flat on her back in front of the dresser with her legs outstretched and her wheelchair next to the bed. Resident #32 complained of right arm pain and had an abrasion to her right elbow which measured approximately three centimeters (cm) by 2 cm. Resident #32 guarded her right arm and cried when the nurse attempted to assess the arm. Review of the facility's SRI (261893) created on 06/22/25 at 5:13 P.M. for allegation of neglect/mistreatment, revealed CNA #168 improperly transferred Resident #32 who required assistance of two staff, and the resident was assessed with a minor abrasion. Registered Nurse (RN) #170 was called to the resident's room where the resident was discovered on the floor of her room. CNA #168 reported she was transferring the resident to a wheelchair by carrying her when CNA #168 tripped during the transfer resulting in the resident falling. The resident was assessed by RN #170 with a small abrasion to the right elbow and wound treatment was initiated. The resident complained of generalized right arm pain but unable to be specific about the pain or a pain level. The resident was contracted at baseline and the resident's range of motion (ROM) in the right arm was not within normal limits. The provider was notified of incident and provided new orders for a stat (immediate) X-ray of the right shoulder and right elbow. The X-ray results were received on 06/23/24 at 12:05 A.M. and Resident #32 had an acute right mildly displaced humeral head fracture. The resident was assessed by the Nurse Practitioner (NP) on 06/23/25 and spoke with family regarding treatment options. A sling was ordered for the resident and no further orthopedic follow up was needed. The resident's pain was managed with Tylenol and ibuprofen, and the family was in agreement with the treatment plan. CNA #168 indicated she was aware Resident #32 required a two-person transfer via mechanical Hoyer lift and transferred the resident by herself. The facility's investigation was unsubstantiated for abuse/neglect related to the incident not meeting definitions of neglect in the regulations. CNA #168 was terminated on 06/27/25 for violations of company policy regarding delivery of patient care. The SRI was completed on 06/27/25 at 12:34 A.M. and unsubstantiated due to evidence indicating abuse, neglect or misappropriation did not occur. Review of the X-ray report dated 06/22/25 at 11:02 P.M. for Resident #32, revealed an acute fracture involving the neck of the right humerus with mild displacement. Review of a witness statement dated 06/22/25 and authored by Registered Nurse (RN) #170, revealed CNA #112 and #168 stated Resident #32 had a fall. CNA #168 reported she attempted to transfer Resident #32 to a wheelchair but tripped and fell with Resident #32. RN #170 reported she observed Resident #32 on the</p>		