STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366445	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Loveland	6405 Small House Circle Loveland, OH 45140

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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, review of water temperature logs, review of a repair quote, and policy review, the facility failed to ensure the residents environment was safe, comfortable, and homelike. This affected nine (#14, #17, #19, #23, #34, #52, #54, #56, and #59) of nice residents reviewed for environment. The census was 58. Findings include: 1. Observation of Resident #19's room on 08/18/25 at 4:10 P.M. revealed the carpet in the resident's room was heavily stained. Observation of Resident #43's bathroom on 08/19/25 at 9:39 A.M. revealed there were three lights above the sink area that were dim to the point they were out. Interview with Maintenance Supervisor (MS) #63 on 08/21/25 at 7:12 A.M. confirmed the carpet in Resident #19's room was heavily stained and stated the lights in Resident #43's bathroom contained light bulbs that would go dim before they were ready to burn out. MS #63 confirmed the bathroom's lighting was very dim. 2. Medical record review for Resident #17 revealed he was admitted to the facility on [DATE]. His diagnoses included congestive heart failure (CHF), pressure ulcer of the right heel, depression, insomnia headache, and cluster headache syndrome. Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 08/05/25 revealed he was cognitively impaired. Resident #17 was dependent on staff for medication administration. He required assistance from staff with eating. He required supervision from staff with oral hygiene, toilet use, bathing and moderate assistance from staff with dressing. Observation on 08/18/25 at 4:26 P.M. revealed Resident #17 had a brown substance that appeared to be dried bowel movement on his toilet seat and around the rim of the toilet and the bathroom floor was soiled with dirt and debris. Resident #17 had a dried substance on his pillow that appeared to be blood, crumbs and food debris throughout the carpet in his bedroom, and the window blinds were torn and had a black substance around the window frame. Interview with Resident #17 on 08/18/25 at 4:26 P.M. revealed he was not sure how often the facility staff clean his room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Certified Nurse Aide (CNA) #105 confirmed Resident #17’s window blinds were torn in his room, confirmed a black substance around his window frame, a dried brown substance on and around his toilet, the black substance throughout his bathroom floor, and the food debris and dirt all around the carpet throughout the bedroom. CNA #105 confirmed the soiled sheets that appeared to have dried blood on the pillow case, and the unknown splattered substance around the doorframe. CNA #105 stated the resident's sheets are usually changed on shower days and as needed. 3. Medical record review for Resident #14 revealed the resident was admitted to the facility on [DATE]. Her diagnoses included dorsalgia, essential primary hypertension, sciatica, dysphagia, atrial fibrillation, cerebral infarction, and depression. Review of the MDS assessment for Resident #14 dated 06/02/25 revealed she was cognitively intact. She was dependent on staff for medication administration and showers. She required set up assistance for oral hygiene and eating. She required maximum assistance from staff with toilet use and dressing. She required moderate assistance with personal hygiene. Interview on 08/19/25 at 9:17 A.M. with Resident #14 revealed the carpet was soiled with dirt and debris scattered throughout the bedroom area. The room had black marks along the wall and around the bathroom area. The toilet seat was soiled, and the bathroom floor appeared to be black and heavily soiled. Interview with Resident #14 on 08/19/25 at 9:17 A.M. revealed her family will clean her bathroom when they visit. Resident #14 stated her family will mop the bathroom floor and clean the toilet. Resident #14 stated she has ongoing issues with her toilet not flushing well. Observation on 08/19/25 at 9:18 A.M. of Resident #14’s bathroom revealed the floor was heavily soiled with black debris and the toilet was soiled. The room had black marks around the wall and debris scattered along the carpet. Interview on 08/21/2025 at 2:32 P.M. with CNA #40 confirmed Resident #14 had a soiled toilet. CNA #40 confirmed Resident #14’s bathroom toilet does not flush well and stated the issue was because Resident #14 had large bowel movements. CNA #40 confirmed the bathroom floor was soiled with black debris and stool was identified around the toilet seat. CNA #40 confirmed a black substance was along the wall when entering the room, around the wall, the bathroom, and under the window. CNA #40 confirmed the carpet had dirt and debris scattered throughout the room. CNA #40 confirmed the chunk of wood missing from the lower part of the bathroom door in Resident #14’s bathroom. 4. Record review of Resident #23's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #23 include hemiplegia, cerebral infarction accident, history right hip fracture, seizure disorder, and hypertension. Review of the MDS assessment dated [DATE] revealed Resident #23 had intact cognition and required moderate staff assistance with bathing. Interview on 08/18/25 at 12:10 P.M., Resident #23 stated he received showers in which the water temperature was cold, even when the staff let the water run. Resident #23 stated he preferred warm showers. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of water temperature logs revealed the hot water temperatures should be between 108 and 120 degree Fahrenheit (F). Further review of the logs revealed Resident #54's water temperatures were between 99 and 101 degrees F between February and July 2025. Resident #52's water temperatures were between 99 and 104 degrees F between February and July 2025. Resident #34's water temperatures were between 77 and 91 degrees F between March and June 2025. Resident #23's water temperatures were between 84 and 101 degrees F between February and July 2025. Resident #56's water temperatures were between 91 and 101 degrees F between February and July 2025. Resident #59's water temperatures were between 89 and 96 degrees F between February and July 2025. Review of a supply quote dated 05/07/25 revealed the facility obtained a quote for repair/replacement of water equipment. Interview on 08/25/25 at 7:25 A.M. with Maintenance Director (MD) #63 verified he obtained the residents' room water temperatures and documented them on the temperature log. MD #63 stated the minimum temperature should be 108 degrees F, per the facility requirements. MD #63 verified he did not get a quote for water repair supplies until May 2025 and stated he should have followed up and implemented an immediate intervention when the water temperature was below the threshold. Interview on 08/25/25 at 7:45 A.M with the Administrator verified MD #63 should have implemented an alternative plan to ensure the water temperatures were within correct range. Review of the facility policy titled, “Resident Rights, dated 01/22/20, revealed the Resident has the right to a clean, and safe environment. The deficiency represents non-compliance investigated under Complaint Number OH00167007 (1399080).

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of a facility policy, the facility failed to ensure fall incidents were reviewed and interventions put in place in a timely manner and failed to ensure established fall interventions were in place as care planned. This affected two (#25 and #64) of six residents reviewed for falls. The census was 58. Findings include:1. Medical record review for Resident #25 revealed she was admitted to the facility on [DATE]. Her diagnoses included, major depressive disorder, essential primary hypertension, generalized anxiety, hallucinations, bipolar disorder, insomnia, anemia, anorexia nervosa, and candidal esophagitis. Review of the Minimum Data Set (MDS) assessment, dated 07/02/25, revealed Resident #25 was cognitively intact. Resident #25 was dependent on staff for medication administration, lower body dressing, and putting on/taking off shoes. Resident #25 required supervision with meals and oral hygiene. Resident #25 required maximum assistance from staff with toilet use, bathing, upper body dressing, personal hygiene, and sit to stand positions. Review of the progress notes for Resident #25, late entry dated on 12/27/25 for 12/23/24 at 9:29 P.M., revealed Resident #25 was found on the floor in Resident #25's room. No immediate intervention was listed. On 12/24/24, Resident #25 was assessed by the nurse practitioner and a stat x-ray was ordered related to Resident #25's complaints of pain. The x-ray results confirmed a probable fracture of the distal clavicle without dislocation and an age indeterminate T12 compression fracture. Review of the interdisciplinary team (IDT) note on 12/26/24 at 1:24 P.M. revealed the IDT met to review the fall from 12/23/24 when Resident #25 was found on the floor by a certified nurse aide (CNA) in front of Resident #25's bed. Resident #25 was assessed by the nurse and denied pain. Resident #25 had complaints of pain with the nurse practitioner visit on 12/24/24 and an order for an x-ray of the left shoulder and lumbar spine was ordered with resulted findings of probable fracture of the distal clavicle and findings of an age indeterminate T12 compression fracture. The IDT intervention was a scoop mattress in place to prevent sliding out of bed. Interview with the Administrator and the Director of Nursing (DON) on 08/21/25 at 9:25 A.M. confirmed no immediate intervention was listed. The Administrator and the DON confirmed the IDT team did not meet until 12/26/25 to review the fall that occurred on 12/23/25 and the intervention put in place at that time was for Resident #25 to utilize a scoop mattress. Review of the progress notes for Resident #25 revealed a late entry dated 04/25/25 at 8:03 A.M. for 04/23/25 at 8:30 A.M. that a CNA attempted to transfer Resident #25 from wheelchair to the shower chair and lowered Resident #25 to the floor. Resident #25 stated she was lowered to the floor. No immediate intervention as listed in the progress notes. Review of the IDT team note dated 05/01/25 at 7:10 P.M. for the fall on 04/23/25 revealed a CNA attempted to transfer Resident # 25 from the wheelchair to the shower chair and lowered Resident #25 to the floor. The intervention was to have Resident #25 utilize two staff members to transfer to the shower chair verses one person for transfer to the shower chair.Interview with the DON on 08/21/25 at 9:30 A.M. confirmed the facility failed to place an immediate intervention in place. The IDT did not meet until 05/01/25 and the intervention for two caregivers to transfer Resident #25 to her shower chair was implemented. Review of the progress notes dated 06/28/25 at 12:30 P.M. for Resident #25 revealed she was sent to the emergency room post fall with head trauma and pain was rated a six out of 10. Resident #25 fell when she attempted to transfer herself. No immediate intervention was listed. Review of the IDT note dated 06/30/25 at 1:31 P.M. for 06/28/25 revealed Resident #25 was discharged to the emergency room for evaluation related to the resident falling, hitting her head, and had complaints of pain. Resident #25 fell when she attempted to transfer herself. The intervention was to encourage Resident #25 to utilize a recliner chair when out of the bed.Interview on 08/21/25 at 9:35 A.M. with the Administrator and the DON confirmed Resident #25 tried to transfer herself and it resulted in a fall. The Administrator and the DON confirmed the facility failed to implement an immediate intervention. Resident #25 was discharged to the emergency room for evaluation on 06/28/25 at 12:30 P.M. per the progress notes and returned to the facility on [DATE] at 4:46 P.M. The IDT met on 06/30/25 and Resident #25's new intervention was placed on 06/30/25. Interview with the Administrator on 08/20/25 at 3:54 P.M. confirmed the facility will meet as an IDT and review falls that have occurred the previous business day. The Administrator confirmed the facility identified concerns related to a delay in the time the IDT members have met in relation to a fall. The Administrator confirmed the facility identified a concern with immediate interventions being identified, documented, and put in place immediately after a fall has occurred. The Administrator and the DON confirmed the facility expectation and the facility fall

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and medical record review, the facility failed to ensure the facility was adequately staffed to provide timely care and services for residents. This affected one (#41) of two residents reviewed for bowel and bladder. The census was 58. Findings include:Review of the medical record revealed Resident #41 was admitted to the facility on [DATE]. Diagnoses included type two diabetes mellitus without complications, severe sepsis without septic shock, cellulitis, rheumatoid arthritis and atrial fibrillation. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 had no behaviors, did not reject care, and did not wander. The resident was dependent for toileting, required substantial assistance with bathing, and was dependent for transfers. Review of the care plan for Resident #41 dated 08/16/25 revealed the resident was frequently incontinent of bladder and bowel. Interview and observation with Resident #41 on 08/20/25 at 8:52 A.M. stated she rang the call light over an hour ago and no one came; however, stated a nurse and a nurse aide came in 30 minutes ago and asked if she needed anything and she let them know she had gone to the bathroom in her pants in the bed. The resident appeared frustrated that she had the accident. Interview with Registered Nurse (RN) #300 on 08/20/25 at 8:55 A.M. confirmed she and the nurse aide went in and asked if Resident #41 needed anything 30 minutes ago and the resident indicated she needed help with toileting and RN #300 was not sure if anyone went in to help her. Interview on 08/20/25 at 8:58 A.M. with RN #300 stated she was going to finish giving medications to another resident and then she would assist Resident #41. Interview on 08/20/25 at 9:00 A.M. with Resident #41 confirmed she was not happy and embarrassed about sitting in soiled pants. She stated it did not happen all of the time, and she was worried because her skin was sensitive. Observation on 08/20/25 at 9:04 A.M. revealed RN #300 walked into Resident #41 ' s room. Interview on 08/20/25 at 9:08 A.M. with CNA #32 verified she was in Resident #41 ' s room about 30 minutes ago and aware at that time the resident had an incontinence accident in her bed, and she added she let the resident know she had to come out and make breakfast for the other residents first.Interview on 08/20/25 at 9:52 A.M. with RN #300 stated it was only her and the nurse aide working at the time they went into Resident #41's room. She stated they were short staffed.Interview on 08/20/25 at 9:55 A.M. with CNA #83 confirmed the facility was short staffed and she just got called in to work at 9:15 A.M. This deficiency represents non-compliance investigated under Complaint Number OH00167007 (1399080), Complaint Number OH00165643 (1399077), and Complaint Number OH00164139 (1399076).

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, staff interview, review of dishwasher, refrigerator, freezer, and food temperature logs, and policy review, the facility failed to ensure foods were stored in a manner to prevent spoilage and contamination and failed to ensure the kitchen and dishware were maintained in a sanitary manner. This had the potential to affect all 58 residents residing in the facility. The census was 58. Findings include: 1. During the initial kitchen tour on 08/18/25 from 8:48 A.M through 10:20 A.M. of each facility house with Dietary Technician (DT) #205 revealed, at 8:48 A.M., there was an open container of sour cream dated 08/04/25 with a used by date of 08/11/25 and an open unmarked package of food, identified by DT #205 to be fish aquarium food. Review of the food temperature log revealed no documentation of prepared food temperatures for all three meals for 15 days in July 2025. There were no refrigerator temperatures logged for August 2025 for refrigerator #2 and no temperatures logged for outside freezer #3 for July and August 2025. Interview with DT #205 verified the outdated sour cream and fish food in the resident food refrigerator, the absent food temperatures and refrigerator and freezer temperatures at the time of discovery.Observation of House #19 on 08/18/25 at 9:18 A.M. revealed the food preparation and work table had a large crack extending across the width of table and had a raised edge measuring approximately 1/8 of an inch with noted food debris. Review of the food temperature log had no temperature recorded for all meals of four days in August 2025. Refrigerator #1 and refrigerator #2 had no temperatures recorded for August 1 through August 17 and freezer #3 had no temperatures recorded for July or August 2025.Interview with DT #205 verified the above findings in House #19 at the time of discovery. Observation of House #9 on 08/18/25 at 9:43 A.M. revealed food temperature logs were not complete for all three meals for July 1 through July 28 and freezer #3 had no temperatures recorded for August 1 through August 4. Interview with DT #205 verified the above findings in House #9 at the time of discovery.Observation of House #5 on 08/18/25 at 10:00 A.M revealed no food temperatures for any of the three meals from August 13 to August 17 were recorded. There were no temperatures documented for refrigerator #1 for 12 days in August 2025 and freezer #3 had no recorded temperatures for all of August 2025.Interview with DT #205 verified the above findings in House #5 at the time of discovery.Observation of House #10 on 08/18/25 at 10:20 A.M. revealed there were no recorded temperatures for freezer #3 for all of August 2025.Interview with DT #205 verified the lack of recorded freezer temperatures in House #10 at the time of discovery.2. Review of the House #5 dishwasher log for August 2025 revealed the log listed the rinse cycle temperature of the dishwasher must reach 180 degrees Fahrenheit (F). Further review of the temperature log revealed on 08/02/25, 08/05/25, 08/07/25, 08/10/25, 08/12/25, 8/15/25, and 08/17/25 the dishwasher rinse cycle varied from 170 to 176 degrees F. There was no evidence the dishwasher was re-ran to attain a higher temperature. There was no documentation of any intervention in the comment section of the log regarding the deficient temperature correction. Review of the House #9 dishwasher log for August 2025 revealed the log listed the rinse cycle temperature of the dishwasher must reach 180 degrees F. Further review of the temperature log revealed on 08/03/25, 8/15/25, and 08/17/25 the dishwasher rinse cycle varied from 172 to 174 degrees F. There was no evidence the dishwasher was re-ran to attain a higher temperature. There was no documentation of any intervention in the comment section of the log regarding the deficient temperature correction. Review of the House #19 dishwasher log for August 2025 revealed the log listed the rinse cycle temperature of the dishwasher must reach 180 degrees F. Further review of the temperature log revealed on 08/04/25, 08/05/25, 08/06/25, 08/08/25, 08/09/25 and 08/10/25, the dishwasher rinse cycle varied from 140 to 146 degrees F. There was no evidence the dishwasher was re-ran to attain a higher temperature. There was no documentation of any intervention in the comment section of the log regarding the deficient temperature correction. Interview on 08/18/25 at 10:25 A.M with DT #205 verified dishwasher temperatures were below the required 180 degrees F during the rinse cycle for House #5, House #9, and House #19.Interview on 08/25/25 at 7:35 A.M. Maintenance Director (MD) #63 stated he had not been notified of the dishwasher rinse cycles not getting up to 180 degrees F in House #5, House #9, and House #19.3. Observation on 08/20/25 at 8:50 A.M. revealed Certified Nurse Aide (CNA) #32 prepared puree food in the same blender bowl for two different batches of food. Between the preparations of the foods CNA #32 handwashed the blender bowl with detergent and rinsed the bowl in water. There was no sanitizer system or chemical sanitizer used between the preparation of the foods. Interview on 08/20/25 at approximately 9:00 A.M., CNA #32 verified she did not use a sanitizer between the food preparation and did not know how to do so. She did not know how she would have

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review. the facility failed to ensure soiled linens were properly handled and failed to ensure proper hand sanitation during wound treatments. This affected two (#2 and #62) of four residents reviewed for infection control measures during care and services. The census was 58. Findings include: 1. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident # 2 include hypertension, cerebral vascular accident affected right side, heart disease, diabetes, and anxiety disorder. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #2 had intact cognition and was dependent for toileting and hygiene assistance. Observation on 08/19/25 at 10:27 A.M. of Certified Nurse Aide (CNA) #90 revealed the CNA exiting Resident #2's room with both arms and hands ungloved carrying uncovered linens, which were touching CNA #90's body. She carried the linens through the hallway to the laundry room which was approximately 40 yards from Resident #2's room. Interview on 08/19/25 at 10:28 A.M. CNA #90 verified she changed Resident #2's linens and carried them with ungloved hands through the hallway to the laundry room. CNA #90 verified the linens were touching her body. She stated she should have bagged the linens but had no bags. Review of facility policy titled, Used Linen Handling, dated May 2013, revealed staff should always wear gloves when handling used linen, and handle linen as little as possible held away from the body and covered when taken to the dirty utility room. 2. Review of Resident #62's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #62 include hypertension, osteoporosis, anxiety disorder, and dementia. Review of the MDS comprehensive assessment dated [DATE] revealed Resident #62 had impaired cognition and required maximum assistance for transfers and set up assistance for eating. Review of physician orders revealed Resident #62 had orders to cleanse bilateral legs with calcium alginate and medihoney, and wrap in kerlix and ACE wrap once each shift. Observation on 08/21/25 at 12:33 P.M. revealed Licensed Practical Nurse (LPN) #88 was observed to apply the treatment to Resident #62's lower extremity skin tears on bilateral legs at three different areas on the legs. LPN #88 did not change gloves or sanitize her hands between treatments of the three different areas on Resident #62's legs. Interview on 08/21/25 at 12:33 P.M. LPN #88 verified she did not change gloves or sanitize her hands between treatments of the three different wound sites on Resident #62's legs. LPN #88 stated she should have changed gloves and sanitized her hands between administration of the treatments between each of the three wound sites. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/25/25 at 3:17 P.M. the Director on Nursing (DON) verified changing gloves and sanitizing hands should occur between application of wound treatments for different wound sites. Review of policy titled, Hand Hygiene Procedure, dated November 2017, revealed hand hygiene occurs after contact with wound dressings. This deficiency represents non-compliance related to Complaint Number OH00167007 (1399080) and Complaint Number OH00165718 (1399078).