| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366445 | A. Building<br>B. Wing | 03/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Otterbein Loveland | 6405 Small House Circle<br>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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of police report, staff interview, resident representative interview, and review of the facility policy manual, the facility failed to ensure the privacy of resident's health information. This affected one (Resident #71) of one resident reviewed for privacy of medical records. The facility census was 56 residents.Findings include:Review of the medical record for Resident #70 revealed an admission date of 09/10/25 with diagnoses including COVID-19, depression, and macular degeneration and a discharge date of 09/30/25. Review of the Minimum Data Set (MDS) assessment for Resident #70 dated 09/30/25 revealed the resident was cognitively intact and required supervision with activities of daily living (ADLs.) Review of nurse progress note for Resident #70 dated 10/01/25 revealed the resident left the facility against medical advice (AMA) on 09/30/25 per the request of the resident's representative. Upon discharge Licensed Practical Nurse (LPN) #142 accidentally provided Resident #70's representative with Resident #71's medications and discharge paperwork by mistake. LPN #142 did not identify the error until shift change when the night shift nurse was unable to find Resident #71's medications in the cart. Review of the medical record for Resident #71 revealed an admission date of 09/17/25 with diagnoses including cerebral infarction, seizures, and sepsis with a discharge date of 10/07/25. Review of the physician's orders for Resident #71 dated 09/30/25 revealed the resident had orders for the following medications: Norvasc, aspirin, Biotin, Cozaar, folic acid, Keppra, Lipitor, methotrexate, metoprolol polyethylene glycol, prednisolone eye drops, sennoside, Synthroid. Review of a police report dated 10/01/25 at 4:05 P.M. revealed on 10/01/25 Resident #70's representative made an in-person report at the police station regarding concerns with the resident's care at the facility. Review of the report revealed the resident's representative reported the resident discharged from the facility on 09/30/25 and discovered the facility had given her medications and written discharge instructions for a different resident. Resident #70's representative stated she had called the facility to notify them, and the staff acknowledged the error. The facility asked the representative to bring the medications and discharge instructions back so the facility could then provide the resident's representative with the correct information and medications. Resident #70's representative requested the police officer accompany her to the facility to make the exchange as she felt uneasy doing so. The officer followed Resident #70's representative to the facility where the medications and discharge instructions were exchanged without issue. Review of the report revealed Resident #70's representative confirmed the resident had not taken any of the medications the facility had provided in error. Interview on 03/24/26 at 3:03 P.M. with the Administrator and the Director of Nursing (DON) reported the nursing staff realized Resident #70 was given the wrong medications and wrong discharge instructions about two to three hours after the resident left the facility. The Administrator confirmed the facility staff called Resident #70's representative regarding the error and the representative said she would bring the medications and discharge instructions back the next day to exchange them for the correct ones. The Administrator confirmed the facility had inadvertently provided Resident #70 and her representative with private health information regarding Resident #71. Interview on 03/25/26 at 11:17 A.M. with Resident #70's representative confirmed upon discharge on [DATE] the facility sent another resident's discharge<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Otterbein Loveland | 6405 Small House Circle<br>Loveland, OH 45140 |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | instructions and medications with the resident. Resident #70 confirmed the facility had given her and the resident private health information about another resident on 09/30/25. Review of the facility Health Insurance Portability and Accountability Act (HIPPA) Manual dated 03/15/22 revealed the facility would protect the privacy and confidentiality of resident's individually identifiable health information. This deficiency represents noncompliance investigated under Complaint Number 2671945. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of police report, staff interview, resident representative interview, and review of the facility policy, the facility failed to provide a safe and orderly resident discharge from the facility. This affected one (Resident #70) of two residents reviewed for discharge. The facility census was 56 residents.Findings include:Review of the medical record for Resident #70 revealed andadmission date of 09/10/25 with diagnoses including COVID-19, depression, and macular degeneration and a discharge date of 09/30/2. Review of the Minimum Data Set (MDS) assessment for Resident #70 dated 09/30/25 revealed the resident was cognitively intact and required supervision with activities of daily living (ADLs.) Review of nurse progress note for Resident #70 dated 10/01/25 revealed the resident left the facility against medical advice (AMA) on 09/30/25 per the request of the resident's representative. Upon discharge Licensed Practical Nurse (LPN) #142 accidentally provided Resident #70's representative with Resident #71's medications and discharge paperwork by mistake. LPN #142 did not identify the error until shift change when the night shift nurse was unable to find Resident #71's medications in the cart. Review of the medical record for Resident #71 revealed an admission date of 09/17/25 with diagnoses including cerebral infarction, seizures, and sepsis with a discharge date of 10/07/25. Review of the physician's orders for Resident #71 dated 09/30/25 revealed the resident had orders for the following medications: Norvasc, aspirin, Biotin, Cozaar, folic acid, Keppra, Lipitor, methotrexate, metoprolol polyethylene glycol, prednisolone eye drops, sennoside, Synthroid. Review of a police report dated 10/01/25 at 4:05 P.M. revealed on 10/01/25 Resident #70's representative made an in-person report at the police station regarding concerns with the resident's care at the facility. Review of the report revealed the resident's representative reported the resident discharged from the facility on 09/30/25 and discovered the facility had given her medications and written discharge instructions for a different resident. Resident #70's representative stated she had called the facility to notify them, and the staff acknowledged the error. The facility asked the representative to bring the medications and discharge instructions back so the facility could then provide the resident's representative with the correct information and medications. Resident #70's representative requested the police officer accompany her to the facility to make the exchange as she felt uneasy doing so. The officer followed Resident #70's representative to the facility where the medications and discharge instructions were exchanged without issue. Review of the report revealed Resident #70's representative confirmed the resident had not taken any of the medications the facility had provided in error. Interview on 03/24/26 at 3:03 P.M. with the Administrator and the Director of Nursing (DON) reported the nursing staff realized Resident #70 was given the wrong medications and wrong discharge instructions about two to three hours after the resident left the facility. The Administrator confirmed the facility staff called Resident #70's representative regarding the error and the representative said she would bring the medications and discharge instructions back the next day to exchange them for the correct ones. Interview on 03/25/26 at 11:17 A.M. with Resident #70's representative confirmed upon discharge on [DATE] the facility sent another resident's discharge instructions and medications with the resident. Resident #70's representative reported the facility did call her about the error and she told the facility she would bring the medications and discharge instructions back the following day. Review of the facility policy titled Discharge/Transfer dated 03/07/25 revealed the facility would develop and implement a discharge planning process involving the resident and/or representative and the interdisciplinary care team to ensure the needs of the resident were identified and there would be a safe transition to a location that met the resident's needs. This deficiency represents noncompliance investigated under Complaint Number 2671945. |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure resident pain medication was available for administration. This affected one (Resident #100) of six residents reviewed for medication availability. The facility census was 56 residents.Findings include: Review of the medical record for Resident #100 revealed an admission date of 09/19/25 diagnoses including osteoporosis and wedge compression fracture of first lumbar vertebra with a discharge date of 09/20/25.Review of the discharge Minimum Data Set (MDS) assessment for Resident #100 dated 9/20/25 revealed the resident's cognition and activities of daily living (ADL) needs were not assessed.Review of the baseline care plan for Resident #100 dated 09/19/25 at 8:15 P.M. revealed the resident was alert and oriented to person, place, and situation, but had a short term memory problem. Resident #100 required supervision with bed mobility, transfers, and toileting and was independent with eating. Resident #100 had lower back pain related to a fall with a fracture and rated her pain as a six on a scale of one to 10 with 10 being the worst pain on 09/19/25 at 8:30 P.M. Review of the physician's orders for Resident #100 revealed an order dated 09/19/25 for oxycodone one five milligram (mg) tablet by mouth every four hours as needed for moderate pain and one to two five mg tablets every four hours for moderate or severe pain for up to twenty doses in total. Review of the Medication Administration Record (MAR) for Resident #100 dated September 2025 revealed staff administered Tylenol 600 mg on 09/19/25 at 9:55 P.M. for a pain level of a six out of 10. Review of the MAR for Resident #100 revealed there were no other pain medications documented for the resident. Review of the pain level summary for Resident #100 dated 09/19/25 revealed the resident had a pain level of a six out of 10 on 09/19/25 at 8:30 P.M., a pain level of a six out of 10 on 09/19/25 at 9:55 P.M. and a pain level of a seven out of 10 on 09/19/25 at 11:24 P.M.Review of the nurse progress note for Resident #100 dated 09/19/25 at 8:30 P.M. revealed the resident was admitted from the hospital and reported last receiving pain medication at the hospital at 4:30 P.M. The nurse called the provider on call to verify Resident #100's admission medication orders and then faxed the medication list and prescriptions to the pharmacy.Review of the progress note for Resident #100 dated 09/19/25 at 9:20 P.M. revealed the nurse called the pharmacy to verify receipt of prescription for oxycodone. The pharmacy provided a code for the nurse to pull two five mg oxycodone tablets from the facility's emergency supply. The nurse attempted to pull the medication with a second nurse and the machine malfunctioned. The drawer did not open to remove the medication. The nurse attempted three more times without success. The nurse then called the pharmacy to alert them she was unable to remove the oxycodone. The pharmacy advised the nurse to contact the the Director of Nursing (DON) or the support number for the emergency supply machine. The nurse then called the Assistant Director of Nursing (ADON) and the DON to notify them of the situation. The nurse continued to attempt to retrieve the medication without success and then called the pharmacy to request immediate delivery of the oxycodone. The pharmacy verified Resident #100's oxycodone should arrive on 09/20/25 at approximately 2:00 A.M. to 3:00 A.M. The nurse then notified Resident #100 of the situation and offered Tylenol. Resident #100 rated her pain as a seven out of 10.Review of the nurse progress note for Resident #100 dated 09/20/25 at 12:45 A.M. revealed the aide notified the nurse the resident was requesting medication. Resident #100 told the nurse she was leaving because the facility did not have her oxycodone and the resident had called her family to come get her. During that time a second nurse arrived at the house and assisted in attempting to retrieve the medication from the machine for a seventh time and was successful. The nurse offered the medication to Resident #100, but the resident refused, because she questioned if the medication was actually oxycodone or a placebo of some kind. Resident #100's family arrived and took the resident away in a private vehicle. Resident #100 and her family member refused to sign discharge paperwork and/or the leaving against medical advice (AMA) form.Interview on 03/26/26 at 1:01 P.M with the Administrator and the DON<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | confirmed Registered Nurse (RN) #15 had attempted to pull Resident #100's oxycodone on 09/19/25 at 9:20 P.M. without success, because the drawer to the emergency supply machine would not open. The Administrator and DON verified RN #15 called the pharmacy and arranged to have the oxycodone delivered between 2:00 A.M. and 3:00 A.M. on 09/20/25. The Administrator stated RN #15 and Licensed Practical Nurse (LPN) #502 tried to open the medication dispensing machine seven times without success. The Administrator stated the nurse administered Tylenol and provided non-pharmaceutical interventions while waiting for the oxycodone to arrive, and Resident #100's pain level was a seven out of ten on 09/19/25 at 11:24 P.M. The Administrator stated on 09/20/25 at 12:45 A.M. Resident #100 told staff she was leaving the facility, and her family was coming to pick her up. The Administrator confirmed the nurses had not notified Resident #100's physician that the facility did not have the resident's oxycodone available for administration.Review of the facility policy titled Controlled Substances Prescriptions dated May 2022 revealed the prescriber would be contacted for directions when the delivery of the medication will be delayed or the medication was not or would not be available. This deficiency represents noncompliance investigated under Complaint Number 2625197 and Complaint Number 2626925. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure staff stored and prepared food in a sanitary manner, failed to ensure dishwasher temperatures reached safe levels, and failed to ensure hot food was held at safe and proper temperatures. This affected 21 (#22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #36, #37, #38, #39, #40, #41, #42, and #43) residents who received food prepared in the House Five kitchen of 56 residents residing in the facility. The facility census was 56 residents. Findings include: 1.Observation on 03/24/26 at 7:54 A.M. of the House Five kitchen refrigerator with Dietary Technician (DT) #506 revealed it contained an undated and uncovered pitcher of pink liquid and a piece of cardboard from a drink box was holding the water dispenser shut on the front of the refrigerator. Observation of the House Five kitchen freezer revealed it contained the following items: two undated medical ice packs, two undated gallon bags full of ice with ice crystals on them, an undated loaf of gluten free bread which was open to air. Further observation of the House Five kitchen pantry revealed there was a bucket full of dirty wash cloths next to a shelf where potatoes were being stored. The pantry freezer had a brown substance in it. The following cabinets in the pantry had a brown substance on them: the cabinet containing the crock pot and skillet, the cabinet containing the mixing bowl, the cabinet containing the cutting board, the cabinet drawer containing the measuring cups. Interview on 03/24/26 at 7:54 A.M with DT #506 confirmed the observations in the House Five kitchen. 2.Observation on 03/24/26 at 8:49 A.M. of the House Five kitchen dishwasher revealed the dishwasher wash temperature was 148 degrees Fahrenheit (F) and the dishwasher rinse temperature was 175 degrees F.Interview on 03/24/26 at 8:49 A.M. with DT #506 verified the dishwasher wash temperature was 148 degrees F and should have been above 160 degrees F, and the dishwasher rinse temperature was 175 degrees F and should have been 180 degrees F. 3.Observation of on 03/24/26 at 9:01 A.M. of food temperatures per Certified Nursing Assistant (CNA) #157 revealed the sausage was being held at 127.6 degrees F during meal service.Interview on 03/24/26 at 9:01 A.M with CNA #157 verified the sausage was being held at 127.6 degrees F during meal service. Review of the facility policy titled Food Temperatures dated May 2013 revealed hot foods must be kept at a temperature of 135 degrees F or higher. 4. Observation on 03/26/26 at 7:43 A.M. of meal preparation in the House Five kitchen revealed CNA #507 was cooking eggs and bacon on an electric skillet. CNA #507 had her hair in a ponytail but was not wearing a hair net.Interview on 03/26/26 at 7:43 A.M. with CNA #507 confirmed she was cooking eggs and bacon on an electric skillet and was not wearing a hair net. This deficiency represents noncompliance investigated under Complaint Number 2673774. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure staff donned proper personal protective equipment (PPE) for residents with physician's orders for enhanced barrier precautions (EBP). This affected one (Resident #31) of two residents with indwelling catheters. The facility census was 56 residents. Findings include: Review of the medical record for Resident #31 revealed an admission date of 01/29/24 with diagnoses including right hip fracture, dementia, insomnia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #31 dated 01/15/26 revealed the resident had severe cognitive impairment and was dependent on staff assistance with activities of daily living (ADLs.) Review of the care plan for Resident #31 dated 01/13/26 revealed the resident had an indwelling catheter related to skin breakdown and urinary retention. Interventions included staff to maintain EBP for the resident due to the presence of the indwelling catheter. Review of the physician's orders for Resident #31 dated March 2026 revealed there was an order for the resident to be in EBP due to the indwelling catheter. Observation on 03/24/26 at 8:35 A.M. revealed there was an EBP cart stocked with personal protective equipment (PPE) outside Resident #31's room Observation of catheter care for Resident #31 on 03/24/26 at 8:45 A.M. per Certified Nursing Assistant (CNA) #75 revealed the aide did not don a gown prior to providing care. Interview on 03/24/26 at 8:56 A.M. with CNA #75 verified that Resident #31 was supposed to be on EBP and the aide had not donned a gown while providing care. Review of the facility policy titled Isolation Precautions Process dated 03/26/25 revealed EBP will be utilized for residents with urinary catheters during their entire stay at the facility. |