STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365321	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of West Kettering The	1150 West Dorothy Lane Kettering, OH 45409

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47914 Based on observation, interview, record review, review of a police report, review of facility document, and policy review, the facility failed to protect the resident's right to be free from sexual abuse by a visitor for one (Resident #137) of three resident's reviewed for abuse. This resulted in Actual Harm on 04/09/24 when Resident #48's significant other, Family Member (FM) #16, touched Resident #137's breasts and private area and exposed his genitalia to the resident on a patio in the facility courtyard where residents smoked. FM #16 admitted to the police that he committed the actions against the resident, despite Resident #137 telling him, No. The failure resulted in Resident #137 being tearful and so traumatized by this event, that it felt like she was raped. Findings included: Medical record review revealed the facility admitted Resident #137 on 07/01/22. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke), schizoaffective disorder bipolar type, tobacco use, depression, generalized anxiety disorder, hemiplegia (paralysis or weakness) affecting the left nondominant side, need for assistance with personal care, and unsteadiness on feet. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/24, revealed Resident #137 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS revealed the resident required supervision or touching assistance (the helper provided verbal cues and/or touching/steadying and/or contact guard assistance as the resident completed the activity) with walking and with upper body dressing. The MDS also indicated the resident had limited range of motion of the upper and lower extremities on one side and utilized a walker. According to the MDS, Resident #137 had no physical, verbal, or other behavioral symptoms. The MDS indicated the resident smoked during the assessment period. Resident #137's Care Plan included a focus area initiated on 04/03/24 that indicated the resident was at risk for injury related to smoking. The Care Plan revealed the resident smoked tobacco-cigarette products and did not need supervision when smoking. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A police report dated 04/09/24 revealed at approximately 1:03 P.M. on 04/09/24, a police officer was dispatched to the facility in response to a Morals/Sex Offenses complaint that occurred from 10:30 A.M. to 11:00 A.M. on 04/09/24. The report revealed upon arrival, the Administrator notified the police officer that Resident #137 had reported that FM #16 inappropriately touched the resident. The report revealed the Administrator had security camera footage from the courtyard of the incident involving Resident #137 and FM #16; however, the video did not have an audio recording aspect. According to the report, the camera footage revealed FM #16 was sitting across from Resident #137 at a table located in the outdoor smoking area (courtyard) of the facility. The report revealed FM #16 was seen standing up and walking toward Resident #137 and positioned himself to stand behind Resident #137 as the resident sat in a chair. The report revealed camera footage showed FM #16 placed his hands and arms across Resident #137's shoulder and FM #16's hands were in motion around Resident #137's breasts for approximately 30 seconds as the resident sat there motionless. According to the police report, FM #16 was then observed moving over to the left side of Resident #137 where FM #16 reached into his own pants. The report revealed FM #16 was observed manipulating something in front of his pants with his left hand. According to the report, Resident #137 briefly looked down at FM #16's private area, slightly leaning away from FM #16, and then looked at FM #16's face. The police report revealed FM #16 placed his right hand on Resident #137's shoulder and slightly pulled the resident toward him. The report revealed FM #16 then zipped up his pants and looked around before placing his right hand and arm inside Resident #137's shirt and began to rub the resident's breast and private area for approximately 25 seconds. According to the police report, once again, Resident #137 sat there motionless and stared forward at the table in front of her. The report revealed FM #16 continued to rub Resident #137's back and hair as the resident stared forward at the table in front of them. The report revealed that it should be noted that a male was seen in the video outside near both parties during a portion of the incident; however, staff advised that the male suffers from mental disabilities and would not be able to give a statement of what occurred. According to the police report dated 04/09/24, Resident #137 stated she was outside smoking when FM #16 began to touch her bare breasts underneath her shirt with bare hands. The report revealed Resident #137 stated FM #16 then proceeded to rub Resident #137's private area through her pants. The report revealed Resident #137 stated she told FM #16, No, multiple times while the actions were occurring. Per the report, Resident #137 stated FM #16 revealed his genital area and stated, I want you to do me a favor, walk to the bathroom and I'll follow you so you can give me a [oral sex]. The report revealed after Resident #137 said no, FM #16 walked away. According to the report, Resident #137 stated she was so traumatized by this event, that it felt like [the resident] was raped. The report revealed that Resident #137 stated she had been at the facility for physical therapy since 03/26/24 and had seen FM #16 outside in the smoking area. The report revealed Resident #137 stated she had several conversations with FM #16 and never felt threatened in any way. The report revealed Resident #137 stated FM #16 usually smelled like alcohol but seemed highly intoxicated that day. The report revealed when the officer asked Resident #137 to complete a written statement, the resident hesitated and agreed that the verbal testimony recorded on the officer's body worn camera would suffice so she did not have to go through the trauma of rearticulating the story again. The report revealed Resident #137 advised the officer that she wanted to pursue charges against FM #16. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	According to the police report dated 04/09/24, the officer left the facility and later arrested FM #16. The report revealed FM #16 stated to the officer that he was at the facility and confirmed standing behind Resident #137 and touching her bare breasts. FM #16 also confirmed hearing the resident say no multiple times but continued to touch the resident's private area through her pants. According to the report, FM #16 stated that Resident #137 still did not approve of FM #16's actions so he stood by the resident's side and showed his genitalia to Resident #137. Observations on 07/08/24 through 07/11/24, revealed a sign posted at the nurse's station of the memory care unit (MCU) that indicated FM #16 is NOT allowed on the premises of the facility. If he/she is in the building you will need to call the police. If you have any questions, please let me know. During an interview on 07/10/24 at 12:05 P.M., the Assistant Director of Nursing (ADON) stated Resident #48 was a long-term resident and FM #16 previously visited them daily. The ADON stated the allegation was reported to the Director of Nursing (DON) and the Administrator and they watched the security footage and called the police who then arrested FM #16. The ADON stated FM #16 was found guilty in a court of law for being sexually inappropriate with Resident #137 due to exposing themselves and groping the resident on the patio. The ADON stated FM #16 was out of jail on probation at the current time but was no longer allowed on the premises. During an interview on 07/10/24 at 12:35 P.M., Resident #32 and Resident #73 stated they were not on the patio when the incident occurred between FM #16 and Resident #137. Per Resident #32 and Resident #73, Resident #137 told them that FM #16 exposed themselves, put their arms down the resident's shirt, and requested they go to the bathroom together. An interview with the DON on 07/10/24 at 3:44 P.M. revealed on 04/09/24, the previous activity director told her that Resident #32 and Resident #73 notified her that FM #16 had inappropriately touched Resident #137 on the smoking patio. The DON stated she watched the video camera footage which showed FM #16 behind Resident #137 with his hands down the resident's shirt and FM #16 exposed himself to the resident. Per the DON, she immediately talked to Resident #137 who confirmed the action was not warranted and wanted to involve the police. The DON stated the facility filed a police report and FM #16 was arrested that day and was then court ordered to not be allowed on the premises moving forward. During an interview on 07/29/24 at 11:23 A.M., the DON stated prior to the incident, FM #16 was a frequent visitor of Resident #48 and visited daily from 8:00 A.M. until approximately 1:00 P.M. to 2:00 P.M. The DON stated that prior to the incident, FM #16 would occasionally go out and smoke and there had never been any issues. According to the DON, FM #16 was arrested the day of the incident and after FM #16 was initially released from jail, they allowed FM #16 supervised visits in the common area with Resident #48. The DON stated the visits were shorter than before, lasted for a week or two, and FM #16 was not allowed to go out and smoke with the residents. The DON stated FM #16 visited around lunch time to feed Resident #48. She stated FM #16 came to the main entrance, checked in with the receptionist, and someone called for staff to bring Resident #48 downstairs to the common area. The DON stated when FM #16 left, the receptionist had staff come down to get Resident #48. The DON stated no one sat with FM #16, but the receptionist and Human Resources/Business Director were in their offices with the door open. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/29/24 at 11:27 A.M., the Administrator stated the immediate actions taken were for FM #16 to be trespassed from the facility. The Administrator stated the police later found and arrested FM #16. The Administrator stated a few weeks after the incident, FM #16 was arrested for another incident and after FM #16 went to court, FM #16 was not allowed to be in the facility at all. During an interview on 07/29/24 at 1:03 P.M., the Receptionist stated that initially after the incident when FM #16 wanted to come to the facility, the visits had to be supervised. The Receptionist stated that when FM #16 came for the supervised visits, she called, and staff brought Resident #48 to visit FM #16 in the common area. The Receptionist stated that after FM #16 had a court date, FM #16 was not allowed in the facility at all. During an interview on 07/29/24 at 1:12 P.M., the Human Resource (HR) Manager stated she was not aware of any other incidents with FM #16. The HR Manager stated she observed FM #16 during supervised visits and only recalled FM #16 coming in about three times. The HR Manager stated presently FM #16 was not allowed back into the facility and she thought FM #16 served jail time. During an interview on 07/29/24 at 1:24 P.M., Licensed Practical Nurse (LPN) #18 stated initially after the incident, FM #16 had supervised visits with Resident #48 in the common area. LPN #18 stated FM #16 only visited a few times. LPN #18 stated that after the incident, signage was also placed at the nurses' station indicating FM #16 was not allowed at the facility. LPN #18 stated FM #16 had not been back to the facility to visit. During an interview on 07/29/24 at 1:37 P.M., Resident #137 stated they were outside smoking alone when FM #16 came out to smoke. Resident #137 stated FM #16 placed their hands down their shirt, and they asked FM #16 to stop. Resident #137 stated they told the DON, and the police were immediately called. Resident #137 stated, as a result of the incident, FM #16 received five years of probation, had to do anger management, and was listed as a sexual offender. Resident #137 stated she felt safe after FM #16 was arrested. According to Resident #137, on one occasion after the incident, they saw FM #16 downstairs at the facility with Resident #48. Resident #137 stated it bothered her that FM #16 was there, but once she let staff know, Resident #137 did not see FM #16 anymore. During an interview on 07/29/24 at 1:43 P.M., Resident #75 stated they observed FM #16 putting their hands over the shoulder and breasts of Resident #137 and Resident #137 was laughing. Resident #75 stated they left afterwards. Resident #75 stated they had never seen FM #16 doing anything to anyone else. During an interview on 07/29/24 at 4:25 P.M., the Social Services Director (SSD) stated she was called in when the Administrator reported the incident to the police. The SSD stated she sat with Resident #137 when the police officer interviewed the resident. The SSD stated Resident #137 was tearful when talking with the officer. The SSD stated she met with Resident #137 for about three days after the incident and she also referred Resident #137 for psychiatric services, but the resident discharged not long after the incident. The SSD stated Resident #137 started having problems with a few of the other residents about the incident, but Resident #137 continued to go outside and smoke. During an interview on 07/30/24 at 4:02 P.M., the Administrator stated her expectation was for the facility to be free from abuse and the residents were protected and safe. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 2016, indicated, the facility will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. This deficiency represents non-compliance investigated under Complaint Number OH00154929.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Oaks of West Kettering The		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 West Dorothy Lane Kettering, OH 45409	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31524 Based on record review, interview, review of facility documentation, and review of facility policy, the facility failed to report an allegation of sexual abuse to the state agency. This affected one (Resident #137) of three residents reviewed for abuse. Findings include: Medical record review revealed the facility admitted Resident #137 on 07/01/22. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke), schizoaffective disorder bipolar type, tobacco use, depression, generalized anxiety disorder, hemiplegia (paralysis or weakness) affecting the left nondominant side, need for assistance with personal care, and unsteadiness on feet. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/24, revealed Resident #137 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. A police report dated 04/09/24 revealed at approximately 1:03 P.M. on 04/09/24, a police officer was dispatched to the facility in response to a Morals/Sex Offenses complaint that occurred from 10:30 A.M. to 11:00 A.M. on 04/09/24. The report revealed upon arrival, the Administrator notified the police officer that Resident #137 had reported Family Member (FM) #16 inappropriately touched the resident. A facility investigation revealed the Administrator signed a handwritten note that indicated she spoke with Resident #137 on 04/10/24, regarding the incident the day prior and the resident stated they were ok. The note revealed the Administrator told the resident that she and social services were available if needed. Further review of the facility investigation revealed a document that indicated FM #16 was in police custody on 04/09/24 at 3:26 P.M. for sexual imposition. There was no documented evidence the facility reported the sexual abuse allegation to the state agency. During an interview on 07/10/23 at 3:44 P.M., the Director of Nursing (DON) stated in April 2024, the former activity director reported that Resident #32 and Resident #73 notified her that FM #16 had inappropriately touched Resident #137 while on the smoking patio. The DON stated she watched the security footage which showed FM #16 behind Resident #137 with their hands down the resident's shirt and FM #16 exposed themselves to the resident. Per the DON, she immediately talked to Resident #137 who confirmed the action was not warranted and wanted to involve the police. The DON stated the facility filed a police report and FM #16 was arrested that day. The DON stated the incident was not reported to the state agency because they were instructed by their owners not to report. Per the DON, this was an allegation of sexual abuse and should have been reported to the state agency. During an interview on 07/11/24 at 9:07 A.M., the Social Services Director (SSD) stated they may have decided not to report the allegation to the state agency because the perpetrator was not a resident or employee. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/24 at 11:15 A.M., the Administrator stated on 04/09/24, the former activity director notified her and the DON that Resident #32 and Resident #73 reported an inappropriate sexual incident between FM #16 and Resident #137 that occurred on the smoking patio. The Administrator further stated they immediately started an investigation but did not report the incident to the state agency because their corporate office instructed them not to report it. The Administrator further stated this incident was an allegation of sexual abuse and should have been reported to the state agency. A facility policy titled, Abuse, Neglect, Exploitation, & Misappropriation of Resident Property, dated 2016, indicated allegations of abuse should be reported to the state agency. This deficiency represents non-compliance investigated under Complaint Number OH00154929.

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NAME OF PROVIDER OR SUPPLIER Oaks of West Kettering The		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 West Dorothy Lane Kettering, OH 45409	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47914 Based on observation, interview, record review, a review of a police report, review of facility documentation, and policy review, the facility failed to have evidence that an allegation of abuse was thoroughly investigated for one (Resident #137) of three residents reviewed for abuse. Specifically, Resident #137 alleged Family Member (FM) #16 sexually abused the resident on 04/09/24. The facility failed to have documented evidence they reviewed facility video [NAME] footage from the time of the incident; failed to have documented evidence they interviewed/obtained statements from the resident, the alleged perpetrator, witnesses, and staff who worked closely with Resident #137; and failed to determine whether abuse was substantiated. Findings included: Medical record review revealed the facility admitted Resident #137 on 07/01/22. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke), schizoaffective disorder bipolar type, tobacco use, depression, generalized anxiety disorder, hemiplegia (paralysis or weakness) affecting the left nondominant side, need for assistance with personal care, and unsteadiness on feet. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/24, revealed Resident #137 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. During an interview on 07/29/24 at 1:37 P.M., Resident #137 stated they were outside smoking alone when FM #16 came out to smoke. Resident #137 stated FM #16 placed their hands down their shirt, and they asked FM #16 to stop. Resident #137 stated they went to the Director of Nursing (DON), and the police were immediately called. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A police report dated 04/09/24 revealed at approximately 1:03 P.M. on 04/09/24, a police officer was dispatched to the facility in response to a complaint Morals/Sex Offenses that occurred from 10:30 A.M. to 11:00 A.M. on 04/09/24. The report revealed upon arrival, the Administrator notified the police officer that Resident #137 reported that FM #16 inappropriately touched the resident. The report revealed the Administrator had security camera footage from the courtyard of the incident involving Resident #137 and FM #16; however, the video did not have an audio recording aspect. According to the report, the camera footage revealed FM #16 placed their hands and arms across Resident #137's shoulder and FM #16's hands were in motion around Resident #137's breasts for approximately 30 seconds as the resident sat there motionless. According to the police report, FM #16 was then observed moving over to the left side of Resident #137 where FM #16 reached into their own pants. The report revealed FM #16 was observed manipulating something in front of their pants with their left hand. The police report revealed FM #16 placed their right hand on Resident #137's shoulder and slightly pulled the resident toward them. The report revealed FM #16 then zipped up their pants and looked around before placing their right hand and arm inside Resident #137's shirt and began to rub the resident's breast and private area for approximately 25 seconds. According to the police report, once again, Resident #137 sat there motionless and stared forward at the table in front of them. The report revealed FM #16 continued to rub Resident #137's back and hair as the resident stared forward at the table in front of them. The report revealed that it should be noted that a male was seen in the video outside near both parties during a portion of the incident; however, staff advised that the male suffers from mental disabilities and would not be able to give a statement of what occurred. According to the incident report, the officer left the facility and later arrested FM #16. A review of the facility's investigation file revealed a 'Learning Circle In-Service Training Record dated 04/09/24 for Abuse, Neglect, Exploitation & Misappropriation with 13 staff signatures. The training record revealed the length of the education, and Content/Objective sections of the form were incomplete. The facility's investigation also contained CNA/RA Bath and Shower Documentation Sheet for some residents and Questionnaire-Resident forms that indicated facility staff asked residents whether they had ever been abused or neglected by anyone in the facility, whether they were familiar with the facility abuse policy, and whether they felt safe in the facility. The facility's investigation revealed a handwritten note signed by the Administrator that indicated the Administrator spoke with Resident #137 on 04/10/24 about the incident the day prior and the resident stated they were ok. The note revealed the Administrator told the resident that social services was available if the resident wanted to talk. Also included in the facility's investigation was a document that indicated FM #16 was in police custody on 04/09/24 at 3:26 P.M. for sexual imposition. The facility's investigation revealed no documented evidence the facility interviewed/obtained a statement from the resident, the accused, or all witnesses, including those that came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the resident the day of the incident, according to facility policy. The investigative file revealed no documentation that the facility had video [NAME] footage or what was found on the footage. Also, according to the investigation file, there was no documented evidence the facility analyzed all evidence and made a determination regarding whether the allegation was substantiated. An observation during the survey on 07/08/24 through 07/11/24 revealed a sign posted at the nurse's station of the memory care unit (MCU) that indicated FM #16 is NOT allowed on the premises of the facility. If he/she is in the building you will need to call the police at. If you have any questions, please let me know. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/10/24 at 3:44 P.M., the Director of Nursing (DON) stated once the allegation was reported, she watched the facility's video [NAME] footage; however, the DON stated the facility no longer had the footage. The DON stated they then talked to Resident #137 and called the police to file a report. The DON stated the facility completed an investigation that included completing the questionnaires and conducting body audits of the residents on the memory care unit. The DON stated there was no incident report regarding the incident. During an interview on 07/11/24 at 11:15 A.M., the Administrator stated on 04/09/24, Resident #137 was brought to her office, and she interviewed the resident. The Administrator stated the resident was uncomfortable with the incident and wanted the police involved. According to the Administrator, they began doing skin assessments and interviewing other residents. During a concurrent interview with the Administrator and DON on 07/29/24 at 3:58 P.M., the Administrator stated they did not have access to the video [NAME] footage from the incident because the video did not save for that long. The DON stated she may have taken notes during the interviews with Resident #137, but she did not document any of the interviews. The DON stated she talked to FM #16 the next time the family member was on site to let them know they were not allowed on the premises. During an interview on 07/30/24 at 2:32 P.M., the DON stated she expected all parties to be interviewed and the facility should then act accordingly. During an interview on 07/30/24 at 4:02 P.M., the Administrator stated she should have documented what Resident #137 told them. A facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 2016, indicated, Once the Administrator and State Agency are notified, an investigation of the allegation violation will be conducted. The policy revealed, 2. Investigation protocol: The person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. Obtain a statement from the resident, if possible, the accused, and each witness. Review the resident's records. The policy revealed, 3. Documentation: Evidence of the investigation should be documented. Further review of the policy revealed, After completion of the investigation, all of the evidence should be analyzed, and the Administrator (or his/her designee) will make a determination regarding whether the allegation or suspicion is substantiated. This deficiency represents non-compliance investigated under Complaint Number OH00154929.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365321	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of West Kettering The	1150 West Dorothy Lane Kettering, OH 45409

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely, quality laboratory services/tests to meet the needs of residents. 47914 Based on interview, record review, and facility document review, the facility failed to obtain laboratory services ordered by the physician for one (Resident #74) of five residents reviewed for urinary catheter/urinary tract infection. Findings include: Medical record review revealed the facility admitted Resident #74 on 03/22/24. According to the Admission Record, Resident #74 had a medical history that included diagnoses of person injured in a traffic collision, fracture of the left femur, fracture of the right femur, multiple fractures of ribs, contusion of the lungs bilaterally, urge incontinence, and a closed fracture of the right lower leg. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/24, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #74 required set up or clean-up assistance from staff with eating. According to the MDS, Resident #74 had an indwelling urinary catheter. The MDS revealed the resident had no active genitourinary or metabolic diagnoses or infections during the assessment period. Resident #74's Care Plan included a focus area initiated on 04/02/24 that indicated the resident had a potential for fluid imbalance related to decreased intake and because the resident required assistance or reminders to take fluids. Interventions directed staff to obtain laboratory work per orders and to notify the physician as needed for abnormal laboratory results (initiated 04/02/24). Resident #74's Comprehensive Metabolic Panel (CMP) and Complete Blood Count (CBC) with differential (w/diff) reported on 06/20/24 at 3:26 PM, revealed the resident had abnormal laboratory results. Resident #74's Progress Notes dated 06/22/24 at 7:11 P.M. revealed Registered Nurse (RN) #6 documented that the physician was aware of the resident's laboratory results and was in to see the resident. According to the note, the physician ordered normal saline intravenous (IV) fluids to be infused for three days, Rocephin 1 gram (g) to be administered daily for five days, and to repeat the laboratory testing as soon as possible (ASAP). Resident #74's physician's telephone orders dated 06/22/24 at 7:00 P.M. revealed an order to repeat a CMP and CBC w/diff on the next lab, ASAP. A Standing Order Daily Log 06/25/24 - 06/25/24 revealed Resident #74's CMP and CBC w/diff laboratory tests were listed; however, the log revealed no documented evidence a blood specimen was obtained for the laboratory testing. During an interview on 07/30/24 at 12:20 PM, Registered Nurse (RN) #6 stated the physician came in on 06/22/24 and reviewed the laboratory results for Resident #74. RN #6 stated she did not recall whether the physician ordered new laboratory tests for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of West Kettering The	1150 West Dorothy Lane Kettering, OH 45409

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/30/24 at 2:32 P.M., the Director of Nursing (DON) stated that nurses printed a form daily that showed who needed blood specimens drawn for laboratory testing. The DON stated the form was kept in a book for the phlebotomist. The DON was not able to obtain any laboratory results for Resident #74 for 06/25/24. The DON stated her expectation was that physician ordered laboratory tests be completed. During an interview on 07/30/24 at 12:06 P.M., the Physician stated he did not remember anything about the laboratory tests for Resident #74 because it had been over a month. The Physician stated he knew that he and other nurse practitioners saw Resident #74 often and were treating the resident. The Physician stated the failure to obtain laboratory tests would not have changed anything with the resident. The Physician stated the resident was sick and was declining very rapidly, and he had spoken with the family about hospice care because there was not much more they could do for the resident. This deficiency represents non-compliance investigated under Complaint Number OH00155486.