

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  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Oaks of West Kettering The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39967</p> <p>Based on observation, staff interview, and record review, the facility failed to ensure the facility's East Unit crash cart included an assembled suction machine with canister, and a backboard. This affected 49 residents (#26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73 and #74) who resided on the East Unit out of the 112 residents at the facility. The facility census was 112.</p> <p>Finding include:</p> <p>Observation of the East Unit crash cart on [DATE] at 7:45 A.M. with Registered Nurse (RN) #56, revealed there was a suction machine sitting on top of the crash cart; however, there was no suction collection canister in place or located in the crash cart. There was also no backboard on the crash cart. Review of the Emergency Crash Cart Checklist for [DATE] at the same time, revealed all dates were blank, indicating the crash cart had not been checked. There was no Emergency Crash Cart Checklist for [DATE], [DATE] and the last time the East Emergency Crash Cart Checklist was documented as being checked was [DATE].</p> <p>Interview with RN #56 on [DATE] at 7:45 A.M., verified the suction machine on the East unit crash cart did not have a collection canister. RN #56 stated the collection canister for the suction machine was in the medication room. RN #56 also verified the East unit crash cart did not have a backboard and verified [DATE] was the time the crash cart was documented as being checked.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 11:25 A.M. revealed the DON was called by an agency nurse on [DATE] and informed that the backboard was missing from the East crash cart and the crash cart needed to be restocked.</p> <p>Review of the facility's census dated [DATE] revealed Resident #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73 and #74 resided on the East unit.</p> <p>Review of the facility's emergency procedure cardiopulmonary resuscitation (CPR) policy dated February 2018 revealed the facility will maintain equipment and supplies necessary for CPR in the facility at all times.</p> <p>(continued on next page)</p>

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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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00160770.</p>		