

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 01/22/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967</p> <p>Based on medical record review, staff interviews, observation, and review of facility policy, the facility failed to ensure a resident's representative was notified when a resident had a change in condition by sustaining a laceration which required sutures and continued wound care. This affected one (#66) of three residents reviewed for notification of change in condition. The facility census was 101.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #66, revealed an admitted [DATE]. Diagnoses included toxic encephalopathy, schizophrenia, chronic viral hepatitis-C, visual hallucinations, auditory hallucinations, alcohol abuse, drug induced akathisia, muscle weakness and dysphagia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #66 dated 11/18/24, revealed Resident #66 had moderate cognitive impairment and the resident required moderate assistance with transfers and sitting to standing.</p> <p>Review of an incident report titled Skin Tear dated 12/15/24 at 11:23 A.M. and authored by Licensed Practical Nurse (LPN) #233, revealed a Certified Nursing Assistant (CNA) reported Resident #66 was bleeding. There was blood noted in the elevator when Resident #66 returned from smoking. A large laceration that was approximately three inches long by one inch wide was noted on the resident's left shin below the knee and a small cut was noted under the resident's right eye. Resident #66 stated when he went to smoke, he used the bathroom downstairs and the sink broke and cut him. The area was cleansed, and steri- strips, an abdominal (ABD) pad along with kerlix were applied. Resident #66's vital signs were obtained, and the resident's physician was notified. There was no indication the resident's representative was notified.</p> <p>Review of an alert note for Resident #66 dated 12/15/24 at 1:18 P.M., and authored by LPN #272, revealed Resident #66's family was in the facility and observed an open area to the resident's left lower extremity. The family called nine-one-one (911) and Resident #66 was transported to the hospital. The physician was made aware.</p> <p>Review of a physician order for Resident #66 dated 12/15/24, revealed the resident was ordered to have the left shin cleansed with normal saline, patted dry, ABD applied, covered with kerlix every day and monitor the steri-strips for placement. The order was discontinued 12/29/24.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the hospital record for Resident #66 dated 12/15/24, revealed Resident #66 was going to the bathroom at his skilled nursing facility when the ceramic sink fell from the wall hitting his knee and causing a laceration. Resident #66's family reported a provider at the facility applied steri-strips and stated the resident did not need to go to the hospital, and he did not require any sutures. Resident #66's family stated they noticed Resident #66's leg was continuing to bleed and the family insisted the resident come to the emergency department for evaluation. Resident #66 was positive for joint pain and had a five-centimeter (cm) laceration noted to the left knee and there was active bleeding noted. The laceration was closed with 17 sutures, Bacitracin applied and then gauze and Coban applied. Resident #66 was discharged from the hospital on 12/15/24 and to follow-up with his primary care provider and have the sutures removed in 12-14 days.</p> <p>Review of the hospital After Visit Summary (AVS) for Resident #66 dated 12/15/24, revealed Resident #66 was seen for an extremity laceration. The resident was diagnosed with a laceration of the lower left extremity which required sutures, and the sutures were to be removed in 12 to 14 days.</p> <p>Interview with the Director of Nursing (DON) on 01/16/24 at 12:54 P.M., revealed she received a phone call on 12/15/24 from the nurse notifying her that the first-floor bathroom handwashing sink fell on Resident #66 cutting his left knee. The DON stated that the physician was notified, and the physician ordered staff to cleanse the area with normal saline, pat dry, apply an ABD pad and apply kerlix. The DON stated that Resident #66's family was not notified. The DON reported Resident #66 was his own responsible party, but his family came to the facility later that day and requested that he go out to the hospital. The DON stated that Resident #66 returned to the facility from the hospital with stitches.</p> <p>Review of the undated change in condition policy revealed the facility will notify the resident, his or her attending physician and resident representative of changes in the resident's medical condition or status.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161103.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967</p> <p>Based on medical record review, staff interviews, observation, review of maintenance logs, and review of facility policy, the facility failed to ensure a resident was free from accidents/hazards. This resulted in Actual Harm when Resident #66 utilized the first-floor restroom on 12/15/24 and while washing his hands, the floating handwashing sink fell on him resulting in a laceration to the left knee that required 17 sutures, the use of antibiotics for infection prevention and continued wound care. This affected one (#66) of three residents reviewed for accidents. The facility census was 101.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #66, revealed an admitted [DATE]. Diagnoses included toxic encephalopathy, schizophrenia, chronic viral Hepatitis-C, visual hallucinations, auditory hallucinations, alcohol abuse, drug induced akathisia, muscle weakness and dysphagia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #66 dated 11/18/24, revealed Resident #66 had moderate cognitive impairment and the resident required moderate assistance with transfers and sitting to standing.</p> <p>Review of an incident report titled Skin Tear dated 12/15/24 at 11:23 A.M. and authored by Licensed Practical Nurse (LPN) #233 revealed a Certified Nursing Assistant (CNA) reported Resident #66 was bleeding. There was blood noted in the elevator when Resident #66 returned from smoking. A large laceration that was approximately three inches long by one inch wide was noted on the resident's left shin below the knee and a small cut was noted under the resident's right eye. Resident #66 stated when he went to smoke, he used the bathroom downstairs and the sink broke and cut him. The area was cleansed, and steri- strips, an abdominal (ABD) pad along with kerlix were applied. Resident #66's vital signs were obtained, and the resident's physician was notified.</p> <p>Review of an alert note for Resident #66 dated 12/15/24 at 1:18 P.M., and authored by LPN #272, revealed Resident #66's family was in the facility and observed an open area to the resident's left lower extremity. The family called nine-one-one (911) and Resident #66 was transported to the hospital. The physician was made aware.</p> <p>Review of a physician order for Resident #66 dated 12/15/24, revealed the resident was ordered to have the left shin cleansed with normal saline, patted dry, ABD applied, covered with kerlix every day and monitor the steri-strips for placement. The order was discontinued 12/29/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the hospital record for Resident #66 dated 12/15/24, revealed Resident #66 was going to the bathroom at his skilled nursing facility when the ceramic sink fell from the wall hitting his knee and causing a laceration. Resident #66's family reported a provider at the facility applied steri-strips and stated the resident did not need to go to the hospital, and he did not require any sutures. Resident #66's family stated they noticed Resident #66's leg was continuing to bleed and the family insisted the resident come to the emergency department for evaluation. Resident #66 was positive for joint pain and had a five-centimeter (cm) laceration noted to the left knee and there was active bleeding noted. The laceration was closed with 17 sutures, Bacitracin applied and then gauze and Coban applied. Resident #66 was discharged from the hospital on 12/15/24 and to follow-up with his primary care provider and have the sutures removed in 12-14 days.</p> <p>Review of the hospital After Visit Summary (AVS) for Resident #66 dated 12/15/24, revealed Resident #66 was seen for an extremity laceration. The resident was diagnosed with a laceration of the lower left extremity which required sutures, and the sutures were to be removed in 12 to 14 days.</p> <p>Review of a MDS note for Resident #66 dated 12/16/24 at 9:47 A.M., revealed Resident #66's care plan was updated related to a skin tear. Care plan goals and interventions were in place at that time.</p> <p>Review of a care plan for Resident #66 dated 12/16/24, revealed Resident #66 had impaired skin integrity related to a skin tear to the left knee and bruising to the right eye. Interventions included apply treatments as ordered, educate the resident, family and caregivers of causative factors and measures to prevent skin injury, include the resident and responsible party in the treatment plan, update the treatment plan as indicated by change in condition or treatment, measure area every week, and observe the wound for signs and symptoms of infection.</p> <p>Review of a hardware store receipt dated 12/16/24 revealed items including a white wall mount sink, drywall repair panels, a drain, and bath faucet were purchased.</p> <p>Review of a health status note for Resident #66 dated 12/29/24 at 6:53 P.M., and authored by LPN #150, revealed the hospital discharge orders from 12/15/24, indicated the resident's sutures were to be removed in 12-14 days and today was day 14. An order was not located in the paper chart or in the electronic medical record (EMR). Resident #66's physician was contacted and verified Resident #66's sutures were to be removed. This nurse found a small dehiscence (opening of a wound), serous sanguineous fluid leaking and there was a lot of heat and swelling to the area. Resident #66's physician gave an order to start Resident #66 on doxycycline (antibiotic) 100 milligrams (mgs) twice a day for ten days and to leave the wound open to air.</p> <p>Review of a health status note for Resident #66 dated 12/29/24 at 6:58 P.M., and authored by LPN #150, revealed LPN #150 and another nurse on the unit attempted to remove the sutures from the left lower extremity. It was noted the wound edge was thought to be closed and well approximated (wound edges close together) except for a small 1 cm by 1 cm opening that began to open up during the suture removal process. Resident #66 stated the process was becoming painful and was afraid the wound would open more, and the resident requested LPN #150 and the other nurse to stop and wait to be seen by the physician in the morning. The nurse reached out to the physician.</p> <p>Review of a physician order for Resident #66 dated 12/29/24, revealed an order for the sutures to be removed from his left lower extremity or knee. The order was discontinued 12/30/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of a health status note for Resident #66 dated 12/30/24 at 3:32 P.M., revealed Nurse Practitioner (NP) #151 provided new orders including cleanse the wound area with normal saline, pat dry, apply bordered gauze daily and as needed. Resident #66 and the resident's sister were notified.</p> <p>Review of a wound care note for Resident #66 dated 12/30/24 and authored by NP #151, revealed the resident was seen for an initial evaluation and management of the wound to the left lower extremity. Resident #66 was alert with cognitive impairment and resided in the memory care unit. Resident #66 denied pain. The staff attempted to apply a dry dressing for a small amount of bleeding to protect the wound but Resident #66 refused multiple times. The nurse reported that the sutures were removed, and Resident #66 was placed on doxycycline on 12/30/24. The wound was listed as in-house acquired, traumatic in etiology and it had full thickness. The wound was 1 cm in length by 4 cm in width and 0.1 cm in depth. Resident #66 was to have a bordered foam dressing three times a week and as needed.</p> <p>Review of a physician order for Resident #66 dated 12/31/24, revealed an order to have the left knee cleansed with normal saline, patted dry, and covered with bordered gauze daily and as needed. The order was discontinued 01/15/25.</p> <p>Review of a physician order for Resident #66 dated 12/31/24, revealed an order for doxycycline 100 mg give one tablet by mouth two times a day for infection prevention for ten days until finished. The order was discontinued 01/10/25.</p> <p>Review of a wound care physician note for Resident #66 dated 01/06/25 and authored by NP #151, revealed the resident was seen for a wound follow up on his left lower extremity. The wound was listed as improved. The wound was 1.5 cm in length by 3.5 cm in width by 0.1 cm in depth. Resident #66 was to have a bordered foam dressing three times a week and as needed.</p> <p>Review of a health status note for Resident #66 dated 01/09/25 at 5:29 P.M., revealed the resident was to continue antibiotics for his wound. Resident #66 was afebrile (without fever) and removed his bandage three times that shift. Resident #66 was educated on keeping the wound clean and dry and the resident taped on a piece of gauze and told the nurse to leave it alone.</p> <p>Review of a physician order for Resident #66 dated 01/13/25, revealed an order to cleanse the area to the left knee wound, apply collagen to the wound bed, lightly pack the wound with Vashe (a wound Solution intended for cleansing, irrigating, moistening, debridement and removal of foreign material) soaked moistened gauze, and covered with a bordered gauze every day and as needed.</p> <p>Review of a wound care physician note for Resident #66 dated 01/13/25 and authored by NP #151 revealed the resident was seen for a wound follow up on his left lower extremity. The wound was listed as improved. The wound was 1.2 cm in length by 2.5 cm in width by 0.3 cm in depth. Resident #66 was to have a collagen sheet applied to the wound bed, lightly pack the wound with Vashe soaked gauze and cover with a bordered gauze every day.</p> <p>Observations of the facility on 01/16/25 from 7:32 A.M. to 2:00 P.M. revealed no concerns related to accidents/hazards. There was a public restroom located on the first floor that had a floating porcelain sink affixed to the wall. The sink was noted to be sitting on a bracket that was affixed to the wall with a strip of caulking on the top of sink.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with Resident #66 on 01/16/25 at 8:10 A.M., revealed he independently walked into and used the first-floor bathroom around the end of December 2024. Resident #66 stated he went to wash his hands, and the handwashing sink fell on him and cut open his left knee. Resident #66 reported that his left knee was bleeding, and he was sent out to the hospital to get stitches. Resident #66 stated he was not aware of his family being notified of the injury but stated they were at the hospital with him. Resident #66 reported that he had a current dressing on his left knee, but his stitches had been taken out. Resident #66 stated his pain was not too bad. Observation of Resident #66 at the time revealed the resident was lying in bed, appeared clean, and the resident was observed to have a bordered dressing on his left knee that was not labeled or dated.</p> <p>Interview with the Administrator on 01/16/25 at 10:19 A.M., revealed the staff took Resident #66 to smoke on 12/15/24 and the staff noticed Resident #66 was bleeding when they got on the elevator to go back up to the resident's unit on the second floor. The Administrator stated Resident #66 reported the sink cut him. Resident #66's physician was notified, and the physician gave an order for a dressing to the wound, but the resident's family was not satisfied and wanted him sent out to the hospital. The Administrator stated Resident #66 was sent to the hospital, and he obtained sutures to his left knee. The Administrator reported the bathroom sink was found lying on the floor when staff looked in the bathroom and the bathroom was locked so other residents could not enter it.</p> <p>Interview with the Director of Nursing (DON) on 01/16/25 at 12:54 P.M., revealed she received a phone call on 12/15/24 from the nurse notifying her the first-floor bathroom handwashing sink fell on Resident #66 cutting his left knee. The DON stated the physician was notified, and the physician ordered staff to cleanse the area with normal saline, pat dry, apply an ABD pad and apply kerlix. The DON stated Resident #66's family was not notified because Resident #66 was his own responsible party, but his family came to the facility later that day and requested that he go out to the hospital. The DON stated that Resident #66 returned to the facility from the hospital with stitches.</p> <p>Attempted interview with LPN #233 on 01/16/25 at 12:56 P.M. was unsuccessful. A message was left to return the call, and no return call was received.</p> <p>Interview with Maintenance Director #800 on 01/16/25 at 12:58 P.M., revealed Maintenance Director #800 was notified on 12/15/24 the sink in the first-floor bathroom fell off the wall and cracked. Maintenance Director #800 reported the sink was on the floor in several pieces and the pipes were still attached to the sink but were not leaking. Maintenance Director #800 stated he replaced the sink with a new floating sink, replaced the dry wall, replaced the drains and applied new caulking. Maintenance Director #800 reported the sink that fell on Resident #66 was a floating sink and floating sinks will tilt if someone puts too much weight on the sink. Maintenance Director #800 stated any floating sink could possibly fall off the wall because floating sinks sit on an anchor with caulking but are not directly bolted to the wall.</p> <p>Observation of wound care for Resident #66's left knee wound on 01/17/25 at 9:34 A.M., revealed LPN #236 washed her hands, donned a gown and gloves. LPN #236 removed an undated bordered dressing from Resident #66's left knee. LPN #236 doffed her gloves, washed her hands and donned a new pair of gloves. LPN #236 cleansed the area with Vashe wound solution, applied collagen to the wound bed, packed the wound with Vashe moist gauze and covered the wound with a bordered gauze. LPN #236 then labeled the dressing with the date and her initials.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with Activities Aide (AA) #801 on 01/17/25 at 1:02 P.M., revealed she took Resident #66 to smoke outside on the first floor of the facility on 12/15/24. AA #801 stated Resident #66 finished smoking, and he went to the bathroom on the first floor by himself. AA #801 reported Resident #66 came out of the bathroom and she was not aware that anything occurred in the bathroom because she did not hear anything as she was watching the bathroom door from a distance. AA #801 stated Resident #66 was wearing dark pajama pants, and she initially did not see any blood. AA #801 reported they went back upstairs from smoking, and she saw a few red drops in the elevator, but she thought it was juice. AA #801 stated Resident #66 stated he was going to talk to the nurse, and she went on about her day but later found out that the sink fell on Resident #66 in the downstairs bathroom and cut his left knee.</p> <p>Review of the facility's investigating and reporting accidents and incidents policy dated December 2009 revealed all accidents and incidents involving residents, employees, visitors, and vendors occurring in the facility shall be investigated and reported to the administrator.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161103.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967</p> <p>Based on record review, and staff interview, the facility failed to ensure a floating porcelain sink was maintained in a safe manner. This affected one (#66) resident of three residents reviewed for physical environment. The facility census was 101.</p> <p>Findings included:</p> <p>Review of the medical record for Resident #66, revealed an admitted [DATE]. Diagnoses included toxic encephalopathy, schizophrenia, chronic viral hepatitis-C, visual hallucinations, auditory hallucinations, alcohol abuse, drug induced akathisia, muscle weakness and dysphagia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #66 dated 11/18/24, revealed Resident #66 had moderate cognitive impairment and the resident required moderate assistance with transfers and sitting to standing.</p> <p>Review of an incident report titled Skin Tear dated 12/15/24 at 11:23 A.M. and authored by Licensed Practical Nurse (LPN) #233, revealed a Certified Nursing Assistant (CNA) reported Resident #66 was bleeding. There was blood noted in the elevator when Resident #66 returned from smoking. A large laceration that was approximately three inches long by one inch wide was noted on the resident's left shin below the knee and a small cut was noted under the resident's right eye. Resident #66 stated when he went to smoke, he used the bathroom downstairs and the sink broke and cut him. The area was cleansed, and steri- strips, an abdominal (ABD) pad along with kerlix were applied. Resident #66's vital signs were obtained, and the resident's physician was notified.</p> <p>Review of the hospital record for Resident #66 dated 12/15/24, revealed Resident #66 was going to the bathroom at his skilled nursing facility when the ceramic sink fell from the wall hitting his knee and causing a laceration. Resident #66's family reported a provider at the facility applied steri-strips and stated the resident did not need to go to the hospital, and he did not require any sutures. Resident #66's family stated they noticed Resident #66's leg was continuing to bleed and the family insisted the resident come to the emergency department for evaluation. Resident #66 was positive for joint pain and had a five-centimeter (cm) laceration noted to the left knee and there was active bleeding noted. The laceration was closed with 17 sutures, Bacitracin applied and then gauze and Coban applied. Resident #66 was discharged from the hospital on 12/15/24 and to follow-up with his primary care provider and have the sutures removed in 12-14 days.</p> <p>Review of the hospital After Visit Summary (AVS) for Resident #66 dated 12/15/24, revealed Resident #66 was seen for an extremity laceration. The resident was diagnosed with a laceration of the lower left extremity which required sutures, and the sutures were to be removed in 12 to 14 days.</p> <p>Review of an alert note for Resident #66 dated 12/15/24 at 1:18 P.M., and authored by LPN #272, revealed Resident #66's family was in the facility and observed an open area to the resident's left lower extremity. The family called nine-one-one (911) and Resident #66 was transported to the hospital. The physician was made aware.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of a care plan for Resident #66 dated 12/16/24, revealed Resident #66 had impaired skin integrity related to a skin tear to the left knee and bruising to the right eye. Interventions included apply treatments as ordered, educate the resident, family and caregivers of causative factors and measures to prevent skin injury , include the resident and responsible party in the treatment plan, update the treatment plan as indicated by change in condition or treatment, measure area every week, and observe the wound for signs and symptoms of infection.</p> <p>Review of a hardware store receipt dated 12/16/24, revealed items including a white wall mount sink, drywall repair panels, a drain, and bath faucet were purchased.</p> <p>Observations of the facility on 01/16/25 from 7:32 A.M. to 2:00 P.M., revealed no concerns related to accidents/hazards. There was a public restroom located on the first floor that had a floating porcelain sink affixed to the wall. The sink was noted to be sitting on a bracket that was affixed to the wall with a strip of caulking on the top of sink.</p> <p>Interview with Resident #66 on 01/16/25 at 8:10 A.M., revealed he independently walked into and used the first-floor bathroom around the end of December 2024. Resident #66 stated he went to wash his hands, and the handwashing sink fell on him and cut open his left knee. Resident #66 reported that his left knee was bleeding, and he was sent out to the hospital to get stitches. Resident #66 stated he was not aware of his family being notified of the injury but stated they were at the hospital with him. Resident #66 reported that he had a current dressing on his left knee, but his stitches had been taken out. Resident #66 stated his pain was not too bad. Observation of Resident #66 at the time revealed the resident was lying in bed, appeared clean, and the resident was observed to have a bordered dressing on his left knee that was not labeled or dated.</p> <p>Interview with the Administrator on 01/16/25 at 10:19 A.M., revealed the staff took Resident #66 to smoke on 12/15/24 and the staff noticed Resident #66 was bleeding when they got on the elevator to go back up to the resident's unit on the second floor. The Administrator stated Resident #66 reported the sink cut him. Resident #66's physician was notified, and the physician gave an order for a dressing to the wound, but the resident's family was not satisfied and wanted him sent out to the hospital. The Administrator stated Resident #66 was sent to the hospital, and he obtained sutures to his left knee. The Administrator reported the bathroom sink was found lying on the floor when staff looked in the bathroom and the bathroom was locked so other residents could not enter it.</p> <p>Interview with the Director of Nursing (DON) on 01/16/25 at 12:54 P.M., revealed she received a phone call on 12/15/24 from the nurse notifying her the first-floor bathroom handwashing sink fell on Resident #66 cutting his left knee. The DON stated the physician was notified, and the physician ordered staff to cleanse the area with normal saline, pat dry, apply an ABD pad and apply kerlix. The DON stated Resident #66's family was not notified because Resident #66 was his own responsible party, but his family came to the facility later that day and requested that he go out to the hospital. The DON stated that Resident #66 returned to the facility from the hospital with stitches.</p> <p>(continued on next page)</p>		

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 01/22/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with Maintenance Director #800 on 01/16/25 at 12:58 P.M., revealed Maintenance Director #800 was notified on 12/15/24 the sink in the first-floor bathroom fell off the wall and cracked. Maintenance Director #800 reported the sink was on the floor in several pieces and the pipes were still attached to the sink but were not leaking. Maintenance Director #800 stated he replaced the sink with a new floating sink, replaced the dry wall, replaced the drains and applied new caulking. Maintenance Director #800 reported the sink that fell on Resident #66 was a floating sink and floating sinks will tilt if someone puts too much weight on the sink. Maintenance Director #800 stated any floating sink could possibly fall off the wall because floating sinks sit on an anchor with caulking but are not directly bolted to the wall.</p> <p>Interview with Activities Aide (AA) #801 on 01/17/25 at 1:02 P.M., revealed she took Resident #66 to smoke outside on the first floor of the facility on 12/15/24. AA #801 stated Resident #801 finished smoking, and he went to the bathroom on the first floor by himself. AA #801 reported Resident #66 came out of the bathroom and she was not aware that anything occurred in the bathroom because she did not hear anything as she was watching the bathroom door from a distance. AA #801 stated Resident #66 was wearing dark pajama pants, and she initially did not see any blood. AA #801 reported they went back upstairs from smoking, and she saw a few red drops in the elevator, but she thought it was juice. AA #801 stated Resident #66 stated he was going to talk to the nurse, and she went on about her day but later found out that the sink fell on Resident #66 in the downstairs bathroom and cut his left knee.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161103.</p>