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| 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 11/24/2025 |
| 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) |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, facility policy review, and review of Enhanced Information Dissemination and Collection system (EIDC) the facility failed to ensure an allegation of abuse was investigated and reported. This affected one Resident (#103) of three residents reviewed for falsification of medical records. The facility census was 112. Findings Include: Record review for Resident #103 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease with late onset, vascular dementia with agitation, psychotic disorder with delusions, and delirium (confusion). Review of nurses note dated 10/17/25 at 9:55 P.M. revealed Resident #103 was observed walking up to another resident and pulled their hair. Staff immediately intervened and helped Resident #103 to their room. Review of EIDC records on 11/24/25 at 2:05 P.M. revealed there was no Self-Reported Incident (SRI) for the incident on 10/17/25 at 9:55 P.M. Interview with the Director of Nursing (DON) on 11/24/25 at 2:55 P.M. verified the nurses note but was unable to state why an SRI was not completed. Interview with the Executive Director (ED) on 11/24/25 at 3:40 P.M. verified the presence of the nurses note, further verified there was no SRI completed but there should have been. Further interview stated they were unaware of the incident until noted by the surveyor. ED stated a SRI will be completed today. Review of policy titled Abuse, Neglect and Exploitation, dated 06/11/25, revealed an immediate investigation is warranted when there are reports of abuse. Further review revealed allegations of abuse need to be reported to required agencies no later than 24 hours after an event of abuse that does not involve serious bodily harm. This deficiency represents non-compliance investigated under Complaint Number 2659051.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| (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 - Some</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>Based on observation, staff interview, review of chemical safety data sheet, and facility policy review, the facility failed to ensure chemicals were stored properly. This had the potential to affect all 21 residents on the memory care unit. The facility census was 112. Findings include: Observation on 11/24/25 from 9:15 A.M. through 9:20 A.M. of the Memory Care unit revealed the biohazard room was unlocked with sharps containers present that contained used needles and other medical supplies. Further observation revealed the shower room was unlocked with prescription Nystatin powder, Zinc/Nystatin cream, and Micro-Kill Two Germicidal Wipes on top of the unlocked cabinet. The Micro-Kill Two Germicidal Wipes container label had keep out of reach of children listed. Interview at the time of the observation with the Director of Nursing (DON) confirmed the prescription Nystatin powder, Zinc/Nystatin cream, and Micro-Kill Two Germicidal Wipes should be stored in a locked cabinet. Interview also confirmed the Micro-Kill Two Germicidal Wipes label had keep out of reach of children listed. Review of the Safety Data Sheet for Medline Micro-Kill Two Germicidal Wipes, dated 12/27/23 revealed the product is classified as acute toxicity for oral ingestion and to keep out of the reach of children. Review of the Chemical Storage policy, dated 09/01/25 revealed chemicals must never be left unattended or stored in resident-accessible areas. This deficiency represents non-compliance investigated under Complaint Number 2647597.</p> | | |