| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365321 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oaks of West Kettering The | 1150 West Dorothy Lane<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on medical record review, observations, staff interviews, and policy reviews, the facility failed to provide a resident who required assistance with activities of daily living (ADL) timely assistance with toileting hygiene. This affected one (#8) of three residents reviewed for ADLs. The facility census was 106.Findings include:Review of the medical record for Resident #8 revealed an admission date of 04/03/26. Diagnoses included encephalopathy, chronic kidney disease stage III, and anxiety. Review of a Nursing admission assessment, dated 04/03/26, revealed Resident #8 was alert and oriented to person only and required set-up assistance with toilet hygiene, bed mobility, and substantial/maximum staff assistance for transfers. Resident #8 was frequently incontinent of bladder and always continent of bowel. Observations on 04/08/26 from 7:39 A.M. to 8:03 A.M. revealed Resident #8 was in his geri-chair in the common area on the hall. Resident #8 was lying back in the geri-chair on his right side. Resident #8's sweatpants appeared to be wet near his peri-area and buttocks. Resident #8 was yelling out that he had to pee. At 7:50 A.M., nursing staff were in the hallways passing breakfast trays and Resident #8 continued to yell out that he had to pee. At 7:52 A.M., Certified Nursing Assistant (CNA) #241 approached Resident #8 with his breakfast tray. Resident #8 informed CNA #241 that he had to go to the bathroom and CNA #241 stated she would help him with his bathroom needs after breakfast. CNA #241 put Resident #8's geri-chair into an upright position, assisted with positioning to a sitting position, and then pushed the geri-chair to the table where Resident #8's breakfast tray was sitting. At 7:58 A.M., Resident #8 was eating his breakfast. Interview on 04/08/26 at 8:00 A.M. with Licensed Practical Nurse (LPN) #237 stated staff were to provide toileting cares/services with routine rounds and as needed. LPN #237 stated the expectation was for staff to toilet residents prior to breakfast if requested by the resident. Interview on 04/08/26 at 8:03 A.M. with CNA #241 confirmed Resident #8 had been calling out that he had to pee and she told him she would assist with his toileting needs after breakfast. CNA #241 stated she had not observed Resident #8's pants to be wet and confirmed she sat Resident #8 at the table to eat breakfast and did not address his toileting needs. Observation with interviews on 04/08/26 at 8:10 A.M. revealed CNA #271 and LPN #265 provide toileting and incontinence cares for Resident #8. CNA #271 stated she had assisted Resident #8 with toileting needs around 7:15 A.M. that morning. LPN #265 confirmed Resident #8's sweatpants and incontinent brief were both wet with urine. No concerns were observed during incontinence care.Review of the facility policy titled Perineal Care,' revised 06/01/25, revealed the facility was to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, to prevent infection to the extent possible, and to prevent and assess for skin breakdown.Review of the facility policy titled Promoting/Maintaining Resident Dignity reviewed 06/11/25 revealed the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. This deficiency represents non-compliance investigated under Complaint Numbers 2795903 and 2791742. |

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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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observations, staff interviews and policy review, the facility failed to properly store the resident's medications in the medication carts. This affected three of three medications carts observed. The facility had a total of six medication carts. The facility census was 106.Findings include:Observation with interview on 04/07/26 at 9:23 A.M. of Central One medication cart with Licensed Practical Nurse (LPN) #205 revealed 20 loose pills scattered on the bottom of the top drawer of the medication cart under the resident's pill cards. All the pills were of different sizes and colors. Observation of Central Two medication cart with LPN #205 revealed eight loose pills scattered on the bottom of the top drawer of the cart under the resident's pill cards. All the pills were of different sizes and colors. LPN #205 confirmed both carts had pills scattered on the bottom of the drawers and the medications were not properly stored. LPN #205 stated the expectation was for staff to discard any medications that fall from the pill cards to the bottom of the drawer. Observation with interview on 04/07/26 at 12:00 P.M. of [NAME] Two medication cart with LPN #215 revealed ten loose pills scattered on the bottom of the top drawer under the resident's pill cards. The pills were of different sizes and colors. LPN #215 confirmed the pills were not stored properly and should have been discarded.Interview on 04/08/26 at 8:46 A.M. with the Director of Nursing (DON) stated the facility had a total of six medication carts. The DON also confirmed that staff were to discard any pills that were found on the bottom of the medication cart drawers. The DON confirmed the facility medication storage and medication administration policies did not address staff procedure for when loose pills were found in the medication carts. This deficiency represents non-compliance investigated under Complaint Number 2806644. |

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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 record review, observations, staff and resident interviews, and policy review, the facility failed to initiate Enhanced Barrier Precautions (EBP) for a resident with a dialysis catheter per the facility's policy. This affected one (#23) of three residents reviewed for infection control. The facility census was 106.Findings include:Review of the medical record for Resident #23 revealed an admission date of 03/19/26. Diagnoses included atrial fibrillation, diabetes mellitus, and chronic kidney disease stage IV.The admission Minimum Data Set (MDS) assessment, dated 03/26/26, revealed Resident #23 was cognitively intact and required supervision/touching assistance with toilet hygiene, bathing, transfers, and bed mobility. Resident #23 received dialysis. Review of Resident #23's physician orders revealed an order dated 03/19/26 for hemodialysis in-house on Monday, Tuesday, Thursday, and Friday. There were no orders to support an order for EBP or assessment of dialysis catheter. Observation with interview on 04/07/26 at 9:10 A.M. revealed Resident #23 sitting on the side of his bed eating breakfast. There was no EBP signage posted or personal protective equipment (PPE) cart located near Resident #23's room. Resident #23 stated he received dialysis four times per week and had a dialysis port to his left chest. Resident #23 stated staff assist him with activities of daily living (ADLs) as needed and assess the dialysis port to left chest after dialysis. Resident #23 stated staff had never donned gown or gloves when providing ADL assistance. Interview on 04/08/26 at 1:56 P.M. with Licensed Practical Nurse (LPN) #237 confirmed Resident #23 had a dialysis port to his left chest and the medical record did not have documentation to support an order for EBP. LPN #237 confirmed Resident #23 should have EBP in place because of the dialysis port. LPN #237 also confirmed Resident #23 did not have EBP signage or a PPE cart located outside of his room. Review of the facility policy titled Enhanced Barrier Precautions (EBP), reviewed 07/01/25, revealed the facility will implement EBP for the prevention of transmission of multidrug-resistant organisms (MRDO). EBP referred to an infection control intervention designed to reduce transmission of MRDO that employs targeted gown and gloves use during high contact resident care activities. The order for EBP would be obtained for residents with wounds and/or indwelling medical devices including hemodialysis catheters even if the resident is not known to be infected or colonized. Implementation of EBP included making gowns and gloves available immediately near or outside of the resident's room and are only necessary when performing high-contact care activities. High contact resident care activities include dressing, bathing, transfers, device care, and wound care. This deficiency represents non-compliance investigated under Complaint Number 2806644. |