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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45849 Based on observation, interview, record review, and facility policy review, the facility failed to ensure one (Resident #37) of six residents who required tube feedings received enteral nutrition in a manner that minimized the risk of complications. Specifically, the facility failed to ensure that Resident #37's enteral nutrition (tube feeding) formula was labeled with the date and time the infusion began. Findings included: Medical record review revealed the facility admitted Resident #37 on [DATE]. According to the Admission Record, the resident had a medical history that included diagnoses of persistent vegetative state, anoxic brain damage, gastro-esophageal reflux disease, and gastrostomy status. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #37 was in a persistent vegetative state with no discernable consciousness. The MDS indicated Resident #37 had a feeding tube for nutrition and received 51 percent (%) or more of their calories through tube feedings. Resident #37's Care Plan included a focus area revised on [DATE], that indicated the resident received enteral nutrition/tube feedings related to dysphagia, and persistent vegetative state. Interventions directed staff to provide enteral feedings as ordered (initiated [DATE]). Resident #37's physician Order Summary Report revealed the resident had an order with a start date of [DATE] for enteral feeding of Isosource 1.5 (a tube feeding formula) at 85 milliliters (ml) per hour for 17 hours per day for a total of 1445 ml in 24 hours via a pump. An observation on [DATE] at 3:32 P.M., revealed a container of Isosource 1.5 was hanging at Resident #37's bedside and infusing via a pump at 85 ml per hour. The observation revealed there was no date or time documented on the tube feeding container to indicate when the tube feeding was initiated. An observation on [DATE] at 8:18 A.M., revealed a container of Isosource 1.5 was hanging at Resident #37's bedside and infusing via a pump at 85 ml per hour and approximately 100 ml of formula remained in the container. The observation revealed no date or time was marked on the container. (continued on next page)

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:16 P.M., Registered Nurse (RN) #1 stated she had changed Resident #37's container of tube feeding formula and should have put a label on the container that included the date. RN #1 stated she threw away the container of tube feeding formula the same day she started it and did not think about putting a date on it. During an interview on [DATE] at 3:13 P.M., the Director of Nursing (DON) stated the tube feeding formula needed to be dated and timed to make sure the formula did not go bad. During an interview on [DATE] at 11:05 A.M., the Administrator stated that the tube feeding formula should be dated when it was hung so that everyone knew when it expired. A facility policy titled, Enteral Tube Feeding via Continuous Pump, undated, indicated, The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally. The policy revealed, 5. On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.

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:	(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.	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.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45849 Based on observation, interview, facility document review, and facility policy review, the facility failed to follow the planned menu for the pureed diet for one (Resident #54) of seven residents who received pureed diets. Findings include: Medical record review indicated the facility admitted Resident #54 on 05/17/24. According to the Admission Record, the resident had a medical history that included a diagnosis of dementia. Resident #54's Order Summary Report, with active orders as of 07/11/24, revealed an order with a start date of 07/06/24 for a regular diet pureed texture. Review of the Puree diet Week at a glance document revealed the facility lunch menu for 07/09/24 that indicated a planned menu for the pureed diet included Pureed 2-#8 [two four ounce or two 1/2 cups] scoop [NAME] Marzetti [a baked pasta, meat, and cheese casserole dish] (1 Cup). An observation of the lunch meal service on 07/09/24 at 11:07 A.M., revealed Resident #54, who was on a pureed diet, was served one #8 scoop of pureed [NAME] Marzetti or one half of the required serving. During an interview on 07/09/24 at 11:41 A.M., Dietary [NAME] #11, who plated the pureed meals, stated he usually served 4 ounces of pureed meat. Dietary [NAME] #11 confirmed that he should have served 8 ounces as the dish included pasta and sauce as well as the meat. During an interview on 07/10/24 at 2:50 P.M., the Registered Dietitian (RD) stated her expectation was that staff should be following the menus. The RD stated that incorrect portion sizes could lead to weight loss, dehydration, and affect overall nutritional status. During an interview on 07/11/24 at 9:01 A.M., the Dietary Director (DD) stated staff should refer to the menus for the correct portion sizes, but, due to a recent change in the menu system, she had not been printing the menus with portion sizes. The DD stated the portion size was also on the residents' meal tickets, and staff should follow the portion sizes on the tickets. The DD stated if a resident received the wrong portion size it could lead to weight loss and malnutrition. During an interview on 07/10/24 at 3:13 P.M., the Director of Nursing (DON) stated she expected the staff to follow the menus and serve the proper portion sizes. The DON stated if residents were served the wrong portion size it could lead to weight loss. During an interview on 07/11/24 at 11:05 A.M., the Administrator stated staff should follow the menu. The Administrator stated if the menu was not followed the nutrition would not be the same. (continued on next page)

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Standardized Menus, with a copyright date of 2024, indicated, Policy: The facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances (RDA) of the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences, standardized cycle menus are planned in advance and utilized.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45849 Based on observation, interview, and facility policy review, the facility failed to ensure the high temperature dishwashing machine sanitized at the proper temperature. This failure had the potential to affect 85 of 88 residents who received food from the kitchen. Findings included: During an interview on 07/08/24 at 8:48 A.M., the Dietary Director (DD) stated the dishwashing machine rinse temperature should be 180 degrees Fahrenheit (F). The DD stated she thought the thermostat was broken. During an interview on 07/09/24 at 8:12 A.M., Dietary Aide (DA) #15 stated she had checked the dishwashing machine temperature on the morning of 07/08/24, and the temperature reached 190 degrees F. DA #15 stated, as far as she knew, the dishwashing machine thermostat worked correctly. During an interview on 07/09/24 at 10:04 A.M., the Service Technician, from the dishwashing machine company, indicated there were two thermostats on the dishwashing machine. He stated one thermostat indicated the rinse tank temperature and another thermostat that was toward the back left of the dishwashing machine indicated the final rinse temperature. During an interview on 07/09/24 at 10:06 A.M., DA #15 stated she had been checking the thermostat on the front of the dishwashing machine. This was not the correct thermostat to check for the final rinse temperature. An observation on 07/10/24 at 10:32 A.M. of the facility's high temperature dishwashing machine revealed the final rinse temperature was 120 degrees F. During an interview on 07/10/24 at 11:16 A.M., the Service Technician, from the dishwashing machine company, stated that some of the dish racks were smaller than others and did not trip the lever to engage the final rinse cycle. The Service Technician stated the dishwashing machine was installed on 03/05/24. During an interview on 07/10/24 at 3:13 P.M., the Director of Nursing (DON) stated she expected that part of the kitchen staff's normal routine would be to check the temperature of the dishwashing machine. The DON stated, if the dishwashing machine was not working properly, staff should notify someone so that it could be fixed. During an interview on 07/11/2024 at 11:05 AM, the Administrator stated if the dishwashing machine was not correctly functioning, staff should notify management. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A facility policy titled, Cleaning Dishes/Dish Machine, dated 2023, indicated, Policy: All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The policy further indicated, Note: Staff should check the dish machine gauges throughout the cycle to ensure proper temperatures for sanitation.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45849 Based on observation, interview, record review, and facility policy review, the facility failed to establish and maintain an infection control program to prevent the transmission/development of infection for three (Resident #139, Resident #37, and Resident #5) of seven residents reviewed for infection control. Specifically, the facility failed to ensure that staff implemented Enhanced Barrier Precautions (EBP) for Resident #37 and #139 and failed to appropriately handle dirty linens and store respiratory equipment properly for Resident #5. Findings include: 1. Medical record review indicated the facility admitted Resident #139 on 06/21/24. According to the Admission Record, the resident had a medical history that included diagnoses of sepsis, chronic kidney disease, and neuromuscular dysfunction of the bladder. An admission Minimum Data Set (MDS), with an Assessment Reference Date of 06/28/24, revealed Resident #139 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for toileting needs, had an indwelling urinary catheter, and was frequently incontinent of bowel. Resident #139's Care Plan included a focus area initiated 06/28/24, that indicated the resident had a urinary catheter related to a neurogenic bladder. Interventions directed staff to provide catheter care every shift (initiated on 06/28/24). Resident #139's physician Order Summary Report with active orders as of 07/10/24, revealed an order with a start date of 06/25/24 for an indwelling urinary catheter to be changed as needed. The Order Summary Report revealed an order with a start date of 06/25/24 for catheter care every shift per facility protocol for infection prevention. Observations on 07/10/24 at 9:05 A.M., revealed Registered Nurse (RN) #1 entered Resident #139's room to provide catheter care. The observation revealed no signage indicating a need for EBP was posted. RN #1 donned gloves and provided care. Following care, RN #1 removed her gloves and washed her hands. RN #1 did not don a gown prior to providing catheter care. During an interview on 07/10/24 at 1:59 PM, State tested Nursing Assistant (STNA) #12 stated that when providing care to a resident with a catheter she wore gloves and washed her hands. STNA #12 stated if a resident had a urinary tract infection she would wear a gown, mask, and gloves but otherwise she just wore gloves. 2. Medical record review revealed the facility admitted Resident #37 on 01/08/15. According to the Admission Record, the resident had a medical history that included diagnoses of persistent vegetative state, anoxic brain damage, acute respiratory failure, tracheostomy status, personal history of methicillin resistant staphylococcus aureus infection (an MRDO), pleural effusion, and pneumonia. A quarterly MDS, with an ARD of 06/05/24, revealed Resident #37 was in a persistent vegetative state with no discernable consciousness. The MDS indicated Resident #37 received tracheostomy care. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #37's Care Plan included a focus area revised on 03/01/24 that revealed the resident had the potential for ineffective breathing and required a tracheostomy related to respiratory failure and anoxic encephalopathy. Interventions directed staff to provide tracheostomy care every shift and as needed and to suction as ordered and as needed. Resident #37's physician Order Summary Report with active orders as of 07/10/24 revealed an active order with a start date of 04/10/24 for tracheostomy care every shift. Observations on 07/10/24 at 12:56 P.M. revealed RN #1 providing tracheostomy care to Resident #37. RN #1 donned gloves and provided care. RN #1 did not don a gown. During an interview following the tracheostomy care on 07/10/24 at 1:16 P.M., RN #1 stated she was unaware of enhanced barrier precautions. RN #1 stated she wished that someone would notify them when guidelines were updated. RN #1 stated she would have followed the guidelines for enhanced barrier precautions if she had been aware of them. During an interview on 07/10/24 at 1:33 P.M., STNA #13 stated if Resident #37 had a lot of secretions or was coughing she would wear a mask but would not normally wear a gown. STNA #13 stated she donned the same personal protective equipment for Resident #37 as she did for all residents and believed she was only required to wear gloves. During an interview on 07/10/24 at 2:01 P.M., the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated he was aware of the EBP guidelines but that he thought it was still voluntary and was not mandatory. The IP stated he had not done any training with the staff on EBP. During an interview on 07/10/24 at 3:13 P.M., the Director of Nursing (DON) stated she did not know a lot about EBP except that it was something new. The DON stated she did not know that it was required. During an interview on 07/11/2024 at 11:05 AM, the Administrator stated EBP should have been implemented when the guidelines first came out. A facility policy titled, Enhanced Barrier Precautions Policy, undated, indicated, The purpose of this policy is to reduce the transmission of MDROs [multidrug-resistant organisms] by implementing targeted gown and glove use during specific resident care activities. The policy indicated, EBP [enhanced barrier precautions] should be used for residents with any of the following: Infection or colonization with a CDC [Centers for Disease Control and Prevention] -targeted MDRO when Contact Precautions do not apply. Residents with chronic wounds or indwelling medical devices, regardless of MDRO status. The policy further indicated, EBP should be employed during the following high-contact resident care activities: Device care or use (e.g. [exempli gratia, for example], central line, urinary catheter, feeding tube, tracheostomy/ventilator). 43648 (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Medical record review revealed the facility admitted Resident #5 on 02/29/24. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypercapnia, congestive heart failure (CHF), obstructive sleep apnea, and rheumatoid arthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 06/21/24, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was frequently incontinent of bladder and always incontinent of bowel, was dependent on staff for toileting hygiene, and required substantial to maximal assistance with rolling left and right. The MDS also revealed Resident #5 used a non-invasive mechanical ventilator. Resident #5's Care Plan included a focus area initiated on 03/12/24, that indicated the resident had an alteration in bladder elimination and had the potential for incontinence and wore incontinence pads/briefs. Interventions directed staff to assist with toileting needs and incontinence care on routine rounds (initiated 03/12/24). Further review revealed a focus area initiated on 03/12/24, that indicated the resident was at risk for altered respiratory status/difficulty breathing related to sleep apnea, acute/chronic respiratory failure, CHF, and shortness of breath when lying flat. Interventions directed staff to administer respiratory treatments as ordered and to apply Continuous Positive Airway Pressure (CPAP)/Bi-level Positive Airway Pressure (BiPAP) per order (initiated on 03/12/24). Resident #5's physician Order Summary Report with active orders as of 07/10/24 revealed an active order with a start date of 03/12/24 for supplemental oxygen with BiPAP at night and as needed every shift for chronic obstructive pulmonary disease. The Order Summary Report revealed an active order with a start date of 06/30/24 for ipratropium-albuterol inhalation solution, one vial inhaled orally every six hours as needed for shortness of breath and/or wheezing. Resident #5's Medication Administration Record (MAR) for 07/2024 indicated staff documented that ipratropium-albuterol inhalation solution was administered on 07/09/24 at 5:30 P.M The MAR also revealed staff documented the resident received supplemental oxygen via BiPAP on 07/09/24 and 07/10/24. During an observation on 07/10/24 at 9:15 AM, Resident #5's BiPAP mask and nebulizer mask were uncovered on the resident's nightstand and the end of the tubing for the BiPAP mask was on the floor. The observation also revealed State tested Nursing Assistant (STNA) #9 entered the resident's room to provide incontinence care. The observation revealed STNA #9 used washcloths to clean feces from the resident and tossed each washcloth on the floor after use. The observation revealed after providing care, STNA #9 bagged the soiled linens from the floor for removal from the room. On 07/10/24 at 9:22 A.M., STNA #9 stated she normally put soiled linens in a bag, but this resident did not like her to take too much time, so she cleaned up at the end of the task. She stated soiled linens should go into a bag and not on the floor. On 07/10/24 at 1:57 P.M., the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated he expected nebulizer and BiPAP masks to be bagged when not in use and stated the end of the BiPAP tubing should not be on the floor. He stated he also expected soiled linens to be placed inside a bag and not on the floor. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/10/24 at 3:16 P.M., the Director of Nursing (DON) stated soiled linen should not be placed on the floor, the nebulizer and BiPAP masks should be bagged or kept in a drawer, and the tubing should never be on the floor. On 07/11/24 at 8:17 A.M., the Administrator stated she expected linens not to be placed on the floor. She also stated nebulizer and BiPAP masks should be stored properly in a bag, or a closed drawer and the tubing should not be on the floor. A facility policy titled, Laundry and Bedding, Soiled, revised in August 2009, indicated, Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handline the linen. The policy revealed, 2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use. A facility policy titled, Storing Resident Respiratory Supplies, undated, indicated, Policy: For storing resident supplies it is essential to ensure the safety and well-being of residents who require such equipment. According to the policy, 1. **Proper Storage**: Respiratory supplies should be stored in a clean, dry, and secure location to prevent contamination and damage.