STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365616	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kettering Heights Post Acute	3313 Wilmington Pike Kettering, OH 45429

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, resident interview, and policy review the facility failed to treat residents with dignity and respect when Certified Nurse Aide (CNA) #268 was observed urinating in Resident #50 and #68's closet. This affected two Residents (#50 and #68) out of three residents reviewed for dignity and respect. The facility census was 97.Findings include:1.Medical record review for Resident #50 revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), major depressive disorder, essential primary hypertension, hyperlipidemia, anorexia, gastro-esophageal reflux disease (GERD), mixed hyperlipidemia, and major depressive disorder.Review of the Minimum Data Set (MDS) assessment, dated 12/01/25, for Resident #50 revealed she was cognitively intact. Review of the progress notes dated 12/12/25 at 11:50 A.M. for Resident #50 revealed on 12/09/25 Licensed Social Worker (LSW) #113 visited Resident #50 after an alleged incident with CNA #268. Resident #50 revealed she felt ok after the initial shock wore off.Interview on 01/05/25 at 11:48 A.M. with Resident #50 revealed CNA #268 had attempted to change her depends and appeared to be very confused. Resident #50 stated CNA #268 used a glove that did not fit his hand, and his pinky finger and thumb did not fit into the glove. Resident #50 stated he acted confused. Resident #50 stated she observed CNA #268 open the closet door and could hear him urinate as the urine stream hit a box lying in the closet. Resident #50 stated she and her roommate, Resident #68, began to scream. 2. Medical record review for Resident #68 revealed she was admitted to the facility on [DATE]. Her diagnoses included COPD, chronic respiratory failure with hypoxia, diabetes mellitus (DM), major depressive disorder, adult failure to thrive tachycardia, GERD, and essential hypertension.Review of the Minimum Data Set (MDS) assessment dated [DATE] dated for Resident #68 revealed she was cognitively intact. Review of the progress notes on 12/12/25 at 11:57 A.M. revealed Licensed Social Worker (LSW) #113 visited with Resident #68 on 12/09/25 after an alleged incident with CNA #268. Resident #68 reported an increase in her anxiety immediately following the incident and she reported still being somewhat in shock during the conversation.Review of the Psychiatric Nurse note dated 12/09/25 at 1:43 P.M. for Resident #68 revealed she reported feeling shaken up due to the incident with the CNA #268 earlier in the day. Resident #68 stated she felt scared and unsafe due to this incident.Interview with Resident #68 on 01/05/26 at 12:00 P.M. confirmed on 12/09/25, Resident #68 observed CNA #268 walk into her room open the closet door proceed to urinate on a box in the closet. Resident #68 stated he left the door open and she could see his side profile as he urinated in the closet. Resident #68 stated she began to scream loudly, and CNA #268 started to walk toward her and she did not know why. Resident #68 stated he had urine on his pants. Resident #68 stated she was very upset and confused regarding why CNA #268 would do this.Interview on 01/05/26 at 11:08 A.M. with the Human Resource Manager (HRM) #123 confirmed CNA #268 urinated in the closet of Resident #50 and #68 on 12/09/25. HRM #123 confirmed the facility terminated CNA #268 on 12/15/25 related to not (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treating Resident #50 and #68 with dignity and respect when he urinated in their closet on 12/09/25. Review of the employee chart for Certified Nurse Aide (CNA) #268 revealed his hire date was listed as 11/08/25. CNA #268 was terminated on 12/15/25 for an incident that occurred on 12/09/25. Review of the form titled, Employee Counseling Form, dated 12/15/25, revealed the type of violation was marked as conduct and abuse. The violation date was listed as 12/09/25 at 9:53 A.M. The nature of infarction was listed as the employee, CNA #268, urinated in a resident's room (Resident #50 and #68) in a cardboard box on 12/09/25 at 10:00 A.M. This violated the PACS Code of Conduct.Review of the facility policy titled, PACS Code of Conduct and Business Ethics, undated, revealed the facility is dedicated to providing quality care and other services to each resident, patient, or other individual served. Each person served is an individual entitled to dignity and respect.Review of the facility policy titled, Dignity, dated 2001 confirmed each resident shall be cared for in a manner that promotes and enhances his or her sense of well being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents will be treated with dignity and respect at all times. This deficiency represents non-compliance investigated under Complaint Number 2693364.