

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/27/2025
NAME OF PROVIDER OR SUPPLIER  Walnut Creek Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5070 Lamme Road Kettering, OH 45439	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, review of facility's Self-Reported Incidents (SRI) and investigation, resident interviews, review of personnel file, and staff interviews, the facility failed to ensure the residents were treated with respect and dignity. This affected two (#34 and #40) of five residents reviewed for abuse and dignity. Findings include: Review of the medical record for Resident #34 revealed an admission to 08/30/24 with medical diagnoses of Parkinson's disease, chronic obstructive pulmonary disease (COPD), and depression. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact and was dependent upon staff for toilet hygiene, bathing, bed mobility, and transfers. Resident #34 was always incontinent with bladder and bowel. Review of the facility's SRI number 265729, dated 09/26/25 at 5:08 P.M., revealed on 09/25/25 at 7:30 P.M., Resident #34 stated Certified Nursing Assistant (CNA) #210 failed to provide cares/services for Resident #34 as requested. Resident #34 stated he felt he had been mistreated. Resident #34 reported CNA #210 had been very aggressive when putting him into bed via mechanical lift. Resident #34's stated once in bed, CNA #210 told Resident #34 to turn to his left side which Resident #34 was unable to do independently. Per Resident #34's statement, CNA #210 then informed Resident #34 Well I 'ain't' helping you and left the room with the mechanical lift pad still under Resident #34 and never returned. Per the Employee Reporting form, CNA #210 had been implicated in other situations and received verbal warnings. Review of the personnel file revealed CNA #210 was hired on 06/10/25. On 09/25/25, CNA #210 received disciplinary action, and it was her final written warning. The disciplinary action was for misconduct, lack of professionalism, unsatisfactory work performance, and negligent conduct involving a resident. On 09/25/25, a resident had a concern of terrible customer service. There were several concerns of misconduct involving the resident. CNA #210 refused to sign the disciplinary form. Interview on 10/21/25 at 8:50 A.M. with CNA #201 stated many residents complain that CNA #210 was rude with resident cares/services. Interview on 10/21/25 at 9:11 A.M. with Resident #34 stated a CNA (#210) with blue hair, had changed his clothes, assisted him back to bed via mechanical list, and had changed his incontinence brief. Resident #34 stated CNA #210 then told him to roll to his left side which Resident #34 stated he was unable to do independently. Resident #34 stated CNA #210 got mad at him because he couldn't roll and then CNA #210 left the room with Resident #34 in the bed with his incontinence brief open and mechanical lift pad underneath his body. Resident #34 stated he had to call out to get someone else to help him. Interview on 10/21/25 at 10:46 A.M. with Registered Nurse (RN) #215 confirmed the residents described CNA #210, the aide with the blue hair. Interview 10/27/25 at 8:15 A.M. with Licensed Practical Nurse (LPN) #209 stated many residents complain that CNA #210 was rude with resident cares/services. Interview on 10/27/25 at 10:50 A.M. with Resident #40 stated the night shift aide with blue hair (CNA #210) was not very nice and asked that CNA #210 no longer take care of her. SR #40 stated the DON was aware of her concerns. This deficiency represents non-compliance investigated under Complaint Number 2643951.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 365821	If continuation sheet Page 1 of 3

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Respond appropriately to all alleged violations.  (continued on next page)

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record reviews, resident and staff interviews, review of facility Self-Reported Incidents (SRIs) and investigation, and policy review, the facility failed to ensure staff immediately reported allegations of abuse to administration and failed to complete a thorough investigations into allegations of abuse. This affected two (#34 and #105) of five residents reviewed for abuse. The facility census was 103. Findings include: Review of the medical record for Resident #34 revealed an admission to 08/30/24 with medical diagnoses of Parkinson's disease, chronic obstructive pulmonary disease (COPD), and depression. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 was cognitively intact and was dependent upon staff for toilet hygiene, bathing, bed mobility, and transfers. Resident #34 was always incontinent with bladder and bowel. Review of the facility's SRI number 265729 and investigation, dated 09/26/25 at 5:08 P.M., revealed on 09/25/25 at 7:30 P.M., Resident #34 stated Certified Nursing Assistant (CNA) #210 failed to provide cares/services for Resident #34 as requested. Resident #34 stated he felt he had been mistreated. Review of an Employee Reporting Form, completed by Registered Nurse (RN) #215, revealed a statement by Resident #34 reported CNA #210 had been very aggressive when putting him into bed via mechanical lift. Resident #34's stated once in bed, CNA #210 told Resident #34 to turn to his left side which Resident #34 was unable to do independently. Per Resident #34's statement, CNA #210 then informed Resident #34 Well I 'ain't' helping you and left the room with the mechanical lift pad still under Resident #34 and never returned. Per the Employee Reporting form, CNA #210 had been implicated in other situations and received verbal warnings. The statement from CNA #210 that was obtained via text message which stated CNA #210 and a coworker (unidentified) had put Resident #34 back to bed via mechanical lift and CNA #210 had to go back to the memory care unit for the next 12 hours. No other information was noted in CNA #210's statement about the allegation. The facility's investigation did not include Resident #34's roommate (#33) statement to see if he witnessed the incident and did not include other residents who may have witnessed it and/or have concerns with CNA #210. The investigation did not include any staff statements from other staff who worked the same shift on 09/25/25. The investigation did not have a witness statement from the coworker who CNA #210 stated assisted with the transfer of Resident #34. Interview on 10/21/25 at 9:11 A.M. with Resident #34 stated a CNA (#210) with blue hair, had changed his clothes, assisted him back to bed via mechanical list, and had changed his incontinence brief. Resident #34 stated CNA #210 then told him to roll to his left side which Resident #34 stated he was unable to do independently. Resident #34 stated CNA #210 got mad at him because he couldn't roll and then CNA #210 left the room with Resident #34 in the bed with his incontinence brief open and mechanical lift pad underneath his body. Resident #34 stated he had to call out to get someone else to help him. Interview on 10/21/25 at 10:46 A.M. with RN #215 stated she was informed on 09/26/25 during morning report that a CNA (unidentified) on 09/25/25 had made an allegation of neglect against another aide (CNA #210). RN #34 confirmed the residents described CNA #210, the aide with the blue hair. RN #215 confirmed the allegation of neglect was not immediately reported to Administrator or supervisor on 09/25/25. RN #215 stated she obtained a statement from Resident #34 on 09/26/25 who stated the incident occurred on 09/25/25. Interview on 10/21/25 at 10:56 A.M. with the Administrator confirmed investigation into the allegation of abuse for Resident #34 did not contain any witness interviews and the staff had not immediately reported the allegation of abuse on 09/25/25 until 09/26/25. Interview on 10/27/25 at 10:18 A.M. with the Director of Nursing (DON) confirmed SRI number 265729's investigation did not contain documentation to support witness statements were obtained. The DON also confirmed the allegation of abuse was not reported immediately to Administrator or supervisor as per facility policy. 2. Review of the medical record for Resident #105 revealed an admission date of 09/23/25 with diagnoses including anemia, heart failure, chronic kidney disease stage III, atrial fibrillation, and myelodysplastic syndrome. Resident #105 was discharged on 10/10/25. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #105 was cognitively intact and required partial/moderate staff assistance with bathing, toilet hygiene, bed mobility, and transfers. Review of the facility's SRI number 265724 dated 09/26/25 at 4:34 P.M. stated on 09/25/25 at 9:00 P.M., Resident #105 was being assisted by CNA #211 and Licensed Practical Nurse (LPN) #220 and Resident #105 felt he was rushed with the mechanical lift transfer process and neither staff members were polite. Review of the SRI investigation revealed an Employee Reporting form that was not dated, did not indicate who obtained Resident #105's</p>		