STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365821	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Nursing Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to ensure a thorough investigation was completed when a resident eloped from the facility. This affected one (Resident #89) out of one resident reviewed for elopement. The facility census was 107.Findings include:Review of the medical record for Resident #89 revealed an admission date of 09/12/25. Diagnoses included cardiac arrhythmia, cerebral infarction (stroke), essential hypertension, schizoaffective disorder, bipolar type, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.Review of the Elopement Evaluation for Resident #89 completed on 09/12/25 revealed the resident was at risk of elopement.Review of the care plan for Resident #89 dated 09/22/25 revealed the resident had impaired cognition as evidenced by deficits in memory, judgement, decision making related to Dementia and was at risk for elopement and resided on a secured Memory Care Unit (MCU). Interventions included to monitor, document and report to the medical provider any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, elopement assessments, provide visual aids to locate room, toilet, and redirection as needed.Review of the Behavior Note for Resident #89 dated 10/10/25 at 1:17 P.M. revealed the resident was setting off the alarms and attempting to exit the MCU. The staff redirected each time and secured the unit doors.Review of the Incident Note for Resident #89 dated 10/10/25 at 4:30 P.M. revealed the resident was not in the facility. A missing resident (Code Brown) was called, and the staff began a search for the resident. The Unit Manager located the resident. The resident was brought back to MCU, a complete skin assessment was done, and the resident was placed on one on one (1:1) observation for 72 hours per physician order.Review of the Incident Form dated 10/10/25, provided by the Director of Nursing (DON), revealed an incident was classified as other and the incident location was off the property. Licensed Practical Nurse (LPN) #296 returned from lunch and Resident #89 was not in the MCU. Staff called a code to inform all staff of resident not being located. Unit Manager alerted nurse resident was found. Skin assessment completed, resident placed on one-on-one (1:1), physician was notified, and 1:1 continued for 72 hours.Review of the physician order for Resident #89 dated 10/14/25 revealed the resident met the criteria for placement on the Memory Care Unit (MCU) and would benefit from the structure and activity-based care philosophy. Review of the Modification of the Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #89 had severe cognitive impairment, with behavioral symptoms not directed towards others, rejection of care, and wandering behaviors that did not place the resident at significant risk of getting to a potentially dangerous place outside of the facility. The resident required supervision assistance with ambulation.Interview on 01/12/26 at 12:02 P.M., Registered Nurse (RN) #33 confirmed on 10/10/25 around 4:15 P.M., she received a call from LPN #296 stating Resident #89 was not in the facility and she was unsure how he eloped, but no alarms sounded. RN #33 stated she located Resident #89 on [NAME] Bell Road which was 0.75 miles from the facility. RN #33 stated she got the resident into her car, along (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Administrator who was walking towards the resident when she located the resident. RN #33 stated she drove the resident and the Administrator back to the facility.Interview on 01/12/26 at 12:14 P.M., the Administrator confirmed on 10/10/25 around 4:00 P.M., he was notified Resident #89 eloped from the facility. The Administrator stated Resident #89 was found just down the road and he talked the resident into walking back to the facility by offering him some food. The Administrator was made aware of the differing reports of how the resident was found and brought back to the facility and had no additional statements. Interview on 01/12/26 at 1:53 P.M., LPN #296 stated she was the nurse caring for Resident #89 on 10/10/25 when he eloped from the MCU. LPN #296 stated the facility staff checked all the rooms and bathrooms on and off the MCU once they realized the resident was missing. LPN #296 stated she called the Unit Manager and the Administrator when Resident #89 was not located in the facility. LPN #296 stated Resident #89 was located and brought back to the facility by the Unit Manager.Interview on 01/12/26 at 2:15 P.M., the DON confirmed there was no documented evidence of a thorough investigation being completed when Resident #89 eloped. There was no documentation as to when the resident was last seen, how the resident eloped, and the steps taken to prevent another elopement. The DON stated the immediate intervention was 1:1 for 72 hours. The DON verified the facility did not educate all staff members on elopement risks.Review of the Wandering and Elopement Policy dated 08/2021 revealed that residents will be assessed for wandering risk. If identified as a risk for wandering or elopement, orders will include strategies and interventions to maintain safety. If the resident does elope, the facility will initiate a search. Once found the DON, physician, resident and resident's representative will review the situation and possible need for transfer.This deficiency represents non-compliance investigated under Complaint Number 2677474.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to ensure comprehensive care plans were developed and accurate. This affected two (Residents #14 and #63) out of three residents reviewed for care plans. The facility census was 107.Findings include:Review of the medical record for Resident #14 revealed an admission date of 12/12/25, Diagnoses included abscess of lung without pneumonia, acute respiratory failure with hypoxia, and unspecified severe protein-calorie malnutrition.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact. Resident #14 was independent with eating and lost more than five percent (%) weight in the last month and 10 % in the last six months and was not on prescribed weight loss regimen. There were no nutritional approaches.Review of the physician orders for Resident #14 dated 12/12/25 revealed the resident was ordered to receive a regular diet, regular texture, thin consistency diet.Review of Resident #14's weights since admission revealed resident weighed 109.4 pounds (lbs.) on 12/12/25, 109.4 lbs. on 12/16/25, and 96.0 lbs. on 12/30/25.Review of the weight change progress note for Resident #14 dated 01/13/26, revealed the resident's weight continued with a downward trend. Interview on 01/13/26 at 11:31 A.M., Registered Nurse (RN) #291 confirmed Resident #14 was assessed for being at risk for nutrition and did not have a care plan in place. RN #291 stated the resident should have a care plan in place that addresses the nutritional risk.Review of the active care plans for Resident #14 revealed there was no documented care plan for the resident being at nutritional risk.Review of the medical record for Resident #63 revealed an admission date of 02/02/24. Diagnoses included traumatic brain injury (TBI), sequela, dysphagia, and unspecified severe protein-calorie malnutrition.Review of the Quarterly MDS dated [DATE] revealed Resident #63 had moderate cognitive impairment, required set-up assistance with eating. Resident did not have a swallowing disorder or weight loss and was on a mechanically altered diet.Interview on 01/14/26 at 8:26 A.M., RN #421 confirmed Resident #63 was assessed as a nutritional risk. RN #421 stated the resident's dietary are plan was discontinued on 07/29/25 when the facility had a system change over and the resident did not have a new dietary care plan implemented but should have had one.Interview on 01/14/26 at 3:06 P.M., Regional Director of Clinical Operations (RDCO) #500 stated the facility did not have a policy on care plans.Review of the active care plans for Resident #63 revealed there was no documented care plan for the resident being at nutritional risk.This deficiency represents non-compliance investigated under Complaint Number 2708144.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure neurological (neuro) assessments were completed for residents following unwitnessed falls. This affected one (Resident #110) out of four residents reviewed for assessments. The facility also failed to ensure a resident was properly assessed for a change in condition prior to a hospital transfer. This affected one (Resident #07) out of the four residents reviewed for change in condition. The facility census was 107.Findings include:Review of the medical record for Resident #110 revealed an admission date of 09/11/24. Diagnoses included Diabetes Mellitus Type II, Vascular Dementia, and Hypertension. Resident #110 was discharged from the facility on 11/08/25.Review of the medical record dated 08/01/25, revealed Resident #110 experienced an unwitnessed fall. Review of the Post-Fall Evaluation for Resident #110 dated 08/01/25 revealed the resident sustained a hematoma (collection or pool of blood that gathers outside of blood vessels, usually forming a lump or swelling due to a broken vessel) on her forehead. Review of nursing documentation and the post-fall monitoring records for Resident #110 revealed no documented evidence of neuro assessments being completed after the unwitnessed fall on 08/01/25.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 had a Brief Interview for Mental Status (BIMS) score of five indicating cognitive impairment.Interview on 01/13/26 at 4:30 P.M., the Director of Nursing (DON) stated neuro assessments were expected to be done following any unwitnessed fall. The DON verified there were no documented neuro assessments completed after Resident #110 had an unwitnessed fall on 08/01/25.Review of the facility policy titled Falls and Fall Risk Managing, dated 08/2021 and reviewed 08/2024, revealed that following an unwitnessed fall or a resident hit their head, nursing staff are to ensure neurological (neuro) checks are initiated. Review of the medical record for Resident #07 revealed and admission date of 12/24/25. Diagnoses included Diverticulitis, Hydronephrosis, and Hypertension. Resident #07 was discharged from the facility on 01/06/26. Review of the care plan dated 12/30/25 revealed Resident #07 was identified as having renal insufficiency related to hydronephrosis (swelling of one or both kidneys caused by a backup of urine, occurring when urine cannot properly drain from the kidney to the bladder due to a blockage, obstruction, or functional issue) and an indwelling catheter, putting her at risk for complications such as but not limited to infection, sepsis, and skin decline. Interventions included to monitor changes in mental status, monitor vital signs as ordered and as needed, and monitor, record, report to medical provider signs and symptoms of urinary tract infection (UTI) including altered mental status and change in behavior.Review of the admission MDS dated [DATE] revealed Resident #07 had a BIMS score of five indicating cognitive impairment. Review of the medical record revealed the last documented nursing assessment for Resident #07 occurred on 01/05/26 at 11:32 P.M. and indicated the resident was alert and oriented, with no acute complaints noted.Review of the medical record for Resident #07 on 01/14/26 at 11:30 A.M. revealed a transfer form was completed on 01/06/26 when Resident #07 experienced a change in condition and was transferred to the hospital transfer. There was no documented evidence of a nursing assessment, recognition or evaluation of a change in condition being completed. Interview on 01/14/26 at 11:43 A.M. the Director of Nursing (DON) confirmed a transfer form for Resident #07 was available for review, which did not contain any clinical data for the resident pertaining to the change in condition. The DON verified no other documentation regarding an assessment on 01/06/26 was available for review. During the interview, the DON confirmed nurses are expected to complete and document an assessment when a resident experiences a significant change in condition.Review of the facility policy titled Transfer and Discharge (Including Against Medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advice [AMA]), dated 04/28/25, revealed that during emergency transfers to acute care staff will document assessment findings and other relevant information regarding the transfer in the medical record.This deficiency represents non-compliance investigated under Complaint Numbers 2647463 and 2710220.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of video footage, review of personnel files, review of Self- Reported Incidents (SRI), and policy review, the facility failed to ensure timely required checks were completed on residents throughout the shift, failed to ensure residents were assessed following an unwitnessed fall and prior to moving the resident off of the floor and placing her back in the bed, failed to ensure the staff appropriately transferred residents following an unwitnessed fall and failed to ensure a post-fall assessment was completed following an unwitnessed fall. This affected one (Resident #01) out of three reviewed for falls. The facility census was 107.Findings include:Review of the medical record for Resident #01 revealed an admission date of 02/26/25 with diagnoses of cerebral atherosclerosis, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, encephalopathy, unspecified, dysphagia, oropharyngeal phase, and essential hypertension.Review of the Care Plan dated 07/17/25 revealed Resident #01 was at risk for falls related to weakness, incontinence, use of psychotropic medication, and dementia. Interventions included assistance from staff with transfers, having the call light within reach, right side of bed against wall and frequent checks by the staff.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #01 had severe cognitive impairment. Resident #01 required substantial assistance bed mobility and transfers.Review of the Fall Risk Evaluation for Resident #01 date 11/14/25 at 8:57 A.M. revealed the resident was at risk for falls.Review of the video footage provided to the facility revealed on 12/23/25 at 11:40:07 P.M. Resident #01 fell out of the left side of the bed, onto her knees, on fall mat and between her bed and the dresser. At 11:40:53, Resident #01 turned herself around and sat on her buttocks with her right leg crossed under her left leg and moaned several times. On 12/24/25 at 5:08:05 A.M. Resident #01 was observed laying directly on the floor, with a pillow under her left side of her body and a couple blankets behind her back, and the resident was laying on her left side. At 5:08:40, Registered Nurse (RN) #386 entered the room, did not say anything to the resident, positioned himself behind her, placed his hands under her arm pits, picked her up and placed her on the bed as the resident moaned. RN #386 got her situated in the bed then RN #386 giggled. RN #386 asked the resident what happened and the resident stated she fell and she had been down there for a while. RN #386 told Resident #01 if she wanted to walk, to walk with a walker, while he picked up the blankets and pillow and placed them onto the bed. RN #386 asked Resident #01 if she had any injuries and RN #386 didn't give the resident a chance to answer before he said no. RN #386 told the resident to use her walker and the resident said she couldn't walk right now. RN #386 picked up the pillows and blankets from the floor, placed the walker in front of her, and administered Resident #01's medication using a spoon RN #386 was talking to the resident, but the words were unintelligible and the resident just stared at RN #386. Review of the Health Status Notes for Resident #01 from 12/23/25 to 12/24/25, revealed no documentation regarding the fall which occurred on 12/23/25 at 11:40 P.M. There was documented evidence of the resident having a post-fall assessment and no documented evidence the physician was notified. Review of the SRI created on 12/24/25 at 5:32 P.M. for an allegation of neglect/mistreatment, revealed Resident #01's family reported the resident had a fall and the nurse did not report the incident. On 12/24/25 at 7:15 P.M., the Administrator was contacted by the facility staff who stated Resident #01's family contacted the facility after they monitored the camera footage from inside the resident's room and reported the resident fell on [DATE]. On 12/24/25 at 5:00 A.M., RN #386 went into the resident's room to administer the morning medication and observed the resident was on the side of the bed lying on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #386 set the medication cup and water down and assisted the resident up from the floor. RM #386 administered the medications and left the room. Review of clinical chart on 12/24/25 at 7:40 P.M. revealed no nurse's note or risk was done for the resident's fall. RN #386 was contacted and concluded that since the resident was care planned for a fall mat, he didn't consider this incident a fall. RN #386 and CNA #385 were suspended until a full investigation was performed. The Administrator watched the video on 12/26/25 which confirmed the incident. RN #386 transferred the resident from the floor to the bed. RN #386 asked if the resident was ok and she thanked him for getting her up.Review of the Health Status Note for Resident #01 dated 12/24/25 at 6:05 P.M. by LPN #327, revealed this nurse was informed by the family that the resident had a fall on the night shift. Video footage was provided to LPN #327 to clarify that there was a fall. Nurse Practitioner (NP) was notified of the fall, and new orders were received to obtain a two view Xray of the left shoulder. Review of the Health Status Note for Resident #01 dated 12/25/25 at 4:26 P.M. revealed the left shoulder x-ray was negative for a fracture or dislocation.Review of the Post Fall Investigation for Resident #01 revealed the facility watched the video provided by the family on 12/26/25 and the staff did not go into the resident's room to check on the resident throughout the night shift. On 12/23/25 at 11:40 P.M. the resident fell out of bed and wasn't discovered on the floor until 12/24/25 at 5:08 A.M., when RN #386 went into the room to administer medications and found Resident #01 on the floor. RN #386 asked the resident if she was okay, then picked the resident up and put back in the bed. The investigation revealed RN #386 did not complete any post-fall assessments, did not document the fall and did not report the fall to anyone. The facility suspended RN #386 and CNA #385 and subsequently terminated both due to incident. Interview on 01/07/25 at 9:06 A.M. Director of Nursing (DON) stated RN #386 and CNA #385 were on duty on 12/23/25 through 12/24/25 and were responsible for the care of Resident #01. The DON stated the two were suspended on 12/24/25 after being notified by Resident #01's family and the lack of checks by the staff. The DON stated that after the investigation was completed both RN #386 and CNA #385 were fired. The DON stated when the facility staff watched the video, no staff entered the resident's room on 12/23/25 through 12/24/25 throughout the shift to check on the resident. The DON stated expectations of staff were to check on residents frequently throughout a shift. The DON verified RN #386 did not complete an assessment on the resident prior to picking her up and putting her in the bed and did not complete a post-fall assessment. The DON verified there was no documentation of the resident's fall and RN #386 did not report the fall to anyone including the physician.Review of the Employee Personnel File for Former CNA #385 revealed a hire date of 09/03/25. Abuse/Neglect training was completed on 09/29/25. CNA #385 was terminated on 01/05/25 due to admitting she failed to frequently check on Resident #01 during the night shift on 12/23/25 through 12/24/25 due to not feeling well. Review of the Employee Personnel File for Former RN #386 revealed a hire date of 10/21/25. Abuse/Neglect training was completed on 11/15/25. RN #386 was terminated on 01/05/25 due to not following policy and procedures with resident falls. RN #386 picked up Resident #01 from the floor and placed the resident back in bed without completing any assessments and failed to document the fall. RN #386 admitted he failed to do a fall assessment on Resident #01.Review of the Falls and Fall Risk, Managing policy dated 08/2021 revealed unwitnessed falls or if resident hit their head will have neurological checks initiated, ensure fall follow up documentation, fall risk evaluation, skin and pain assessments are completed after a fall.This deficiency represents non-compliance investigated under Complaint Number 2703602, 2648250, 2647463, and 2601225.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, the facility failed to ensure the common dining environment was conducive for residents eating in the dining room. This affected two (Residents #24, and #63) out of the six reviewed for dining. This had the potential to affect all 16 residents who ate in the main dining room. The facility census was 107.Findings include:Review of the medical record for Resident #24 revealed an admission date of 09/29/25. Diagnoses included major depressive disorder, permanent atrial fibrillation, adjustment disorder with anxiety, and essential hypertension.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact, required set-up assistance for meals and was on a mechanically altered diet.Review of the medical record for Resident #63 revealed an admission date of 02/02/24 with diagnoses of diffuse traumatic brain injury with loss of consciousness status unknown, sequela, dysphagia, oral phase, dysphagia, pharyngeal phase, dysphagia, pharyngoesophageal phase, personal history of traumatic brain injury and unspecified severe protein-calorie malnutrition.Review of the Quarterly MDS dated [DATE] revealed Resident #63 had moderate cognitive impairment, required set-up assistance with eating and was on a mechanically altered diet.Review of the medical record for Resident #84 revealed an admission date of 07/23/22 with diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease, major depressive disorder, anxiety, and Alzheimer's disease with early onset.Review of the Quarterly MDS for Resident #84 dated 11/17/25 revealed the resident had severe cognitive impairment. Resident #84 had physical behavioral symptoms directed towards others, and verbal behavioral symptoms directed towards others.Observation of dining on 01/05/26 at 12:40 P.M. revealed Resident #84 yelled out non-stop while she was eating lunch. Resident #84 did not appear to be in any distress. Residents (#63 and #24) were seated in the dining room and near Resident #84.Observation of dining on 01/06/26 at 12:05 P.M. revealed Resident #84 yelling non-stop while she was eating lunch. Resident #84 did not appear to be in any distress. Residents (#63 and #24) were seated near Resident #84. Interview on 01/06/26 at 12:07 P.M., Resident #63 stated he was tired of coming to the dining room every day and having to listen to Resident #84 yell out. The resident stated he did not feel like it was fair that all the residents in the dining room had to deal with this behavior every day while they tried to eat. The resident stated he had expressed his concerns to staff and management multiple times.Interview on 01/06/26 at 12:10 P.M., Certified Nursing Assistant (CNA) #268 verified Resident #84 yells out constantly at every meal while seated in the dining room with other residents. CNA #268 stated there were multiple residents seated in the dining room who complained about every meal, but the management team wouldn't remove Resident #84 due to not having enough staff to feed Resident #84 in her room. Interview on 01/06/26 at 12:14 P.M., Resident #24 stated Resident #84 yells at every meal in the dining room. Resident #24 stated she has expressed her concerns to the staff in the dining room, but nothing has ever changed.Interview on 01/06/26 at 12:19 P.M., Licensed Practical Nurse (LPN) #283 confirmed Resident #84 yells continuously while in the dining room and while other residents are dining. LPN #283 stated Resident #84's yelling has become louder and more frequent recently LPN #283 stated Resident #84 was brought to the dining room because there were not enough staff available on the hall to feed the resident in her room. LPN #283 stated there was only one CNA on the hall to assist all other residents during meals.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, staff interviews, and policy review, the facility failed to ensure medications were administered per physician orders and that medication errors were below five percent (%). This affected three (Residents #11, #47, and #112) out of four residents reviewed for medication administration. The facility census was 107.Findings include: Review of the medical record for Resident #11 revealed an admission date of 07/31/25 with diagnoses of cerebral palsy, gastro-esophageal reflux disease without esophagitis, and major depressive disorder. The resident was dependent on staff for medication administration. Review of the physician orders for Resident #11 dated 07/31/25 revealed the resident was ordered to receive 30 milliliters (mL) of Mylanta (heartburn and indigestion) maximum strength oral suspension (400 milligrams (mg) aluminum hydroxide, 400 mg magnesium and 40 mg simethicone) per five mL. twice daily.Review of the medical record for Resident #47 revealed an admission date of 11/11/25 with diagnoses of anemia, cyst of pancreas, gastritis, unspecified without bleeding, vitamin d deficiency, cerebral infarction without residual deficits, essential hypertension, metabolic encephalopathy, other specified diseases of pancreas, and vascular dementia. Review of the physician orders for Resident #47 dated 01/11/25 revealed the resident was ordered to receive 30 mL of lactulose (chronic constipation and to manage high ammonia levels) oral solution 20 grams (gm) per 30 mL. Review of the medical record for Resident #112 revealed an admission date of 01/05/26 with diagnoses of hematuria, chronic diastolic (congestive) heart failure, obstructive sleep apnea, chronic obstructive pulmonary disease, cardiac murmur, anxiety disorder, essential hypertension, single subsegmental thrombotic pulmonary embolism without acute cor pulmonale. Review of the physician orders for Resident #112 dated 01/05/26 revealed the resident was ordered to receive cyanocobalamin (synthetic supplement vitamin B-12) one mg daily. A physician order dated 01/08/26 revealed the resident was ordered to receive apixaban (anticoagulant) five mg twice daily for clotting.Observation of medication administration on 01/12/26 at 8:19 A.M. with Licensed Practical Nurse (LPN) #327 revealed Resident #112 was administered one tablet of vitamin D2 1.25 mg (50,000 international units [IU]). Continued observation of medication administration on 01/12/26 at 8:41 A.M. with LPN #327 revealed Resident #11 was administered 30 ml of Milk of Magnesia (saline laxative) 1200 mg per 15 ml. Continued observation of medication administration on 01/12/26 at 8:50 A.M. with LPN #327 revealed Resident #47 was administered potassium 20 milliequivalent (meq). Interview on 01/12/26 at 9:42 A.M., LPN #327 confirmed Resident #11 was administered 30 ml of Milk of Magnesia LPN #327 stated she did not administer 30 ml of Mylanta maximum strength oral suspension 400-400-40 mg per five 5 mL because she thought Milk of Magnesia was the same as Mylanta. LPN #327 confirmed Resident #47 was not administered his 30 ml of lactulose oral Solution 20 gm per 30 mL. Interview also confirmed Resident #112 was administered vitamin D2 1.25 mg (50,000 IU) without an order. LPN #327 confirmed Resident #112 was not administered cyanocobalamin one mg 1 and Apixaban five mg. Review of the Administering Medications policy dated 08/2021, revealed medications shall be administered in a safe and timely manner, and as prescribed.This deficiency represents non-compliance investigated under Complaint Number 2575203.

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 01/14/2026
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)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, staff interviews, and review of the facility policy, the facility failed to ensure residents were served food to meet their needs. This affected one (Resident #104) out of three residents reviewed for proper diets. The facility census was 107.Findings include:Review of the medical record for Resident #104 revealed an admission date of 05/17/22 with diagnoses of vascular dementia, moderate, with other behavioral disturbance, chronic obstructive pulmonary disease, unspecified, essential (primary) hypertension, and adult failure to thrive. Review of the physician order dated 01/13/25 revealed Resident #104 was ordered to receive a regular diet, mechanical soft texture, regular consistency with regular texture food / snacks as desired with supervision. Review of the Care Plan dated 06/09/25 revealed Resident #104 was at risk for malnutrition/alteration in nutritional status related to dementia with behaviors, history of failure to thrive, depression/anxiety, diabetes, chronic obstructive pulmonary disease (COPD), and cerebrovascular accident. The resident received mechanically altered diet and snacks with supervision. Review of the Annual Minimum Data Set (MDS) assessment for Resident #104 dated 12/04/25 revealed the resident had severe cognitive impairment. Observation of meal service on 01/06/26 at 12:24 P.M. revealed Resident #104 received mechanically altered meatballs, unaltered green beans, and whole grapes. The resident was eating the grapes whole and there was no staff present in the room while the resident was eating. Interview on 01/06/26 at 12:25 P.M., Licensed Practical Nurse (LPN) #283 verified Resident #104 was ordered to receive a mechanically altered meal. LPN #283 confirmed Resident #104 was served whole grapes on her meal tray. LPN #283 verified the resident was alone in her room eating whole grapes and whole grapes were not considered a mechanically altered diet. Interview on 01/06/25 at 12:40 P.M., [NAME] #309 confirmed Resident #104 was ordered to receive a mechanically altered diet and whole grapes should not have been served to any resident on a mechanically altered diet due to whole grapes being a choke risk. Review of the Policy and Procedure of Texture and Consistency-Modified Diets dated 2021 revealed a physician order is needed for a modified diet and the food and nutrition services department will be responsible for preparing and serving the correct consistency of food as ordered. This deficiency represents non-compliance investigated under Complaint Number 2708144 and 2644953

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 01/14/2026
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and policy review, the facility failed to ensure the refrigerators were clean and free from expired foods. This had the potential to affect 106 residents with exception of Resident #42 who the facility identified as being nothing by mouth (NPO). The facility census was 107.Findings include: Observation on 01/08/26 at 2:37 P.M. with the Director of Nursing (DON) revealed the resident refrigerator on the 100-Hall, Skilled Hall and 200-Hall was dirty, with a moist hand towel lying inside the refrigerator on the top shelf, with brown stains scattered throughout the towel. There were four personal containers of various food items, unlabeled and undated. There were multiple bottles of opened, iced coffee in the refrigerator without names or dates noted on the bottles, there was no expiration date present on the bottles. The attached freezer was noted with a frozen red substance on the floor of the freezer. The thermometer was laying upside down, on the floor of the freezer, and was stuck and unable to move. There were two cups of Dairy Queen ice cream in the freezer, with straws sticking out of the top of the lids, undated and unlabeled. There were two personal containers of food in the freezer, undated and unlabeled. There was no temperature or cleaning log present on or around the refrigerator /freezer. Interview on 01/08/26 at 2:37 P.M. at the time of observation with the DON confirmed the findings in the 100-hall, Skilled Hall and 200-hall. Interview also confirmed that the refrigerator / freezer should be cleaned and temperature checked daily. Interview confirmed the cleaning and temperature logs were missing. The DON stated there was no policy on cleaning the residents' refrigerators.This deficiency represents non-compliance investigated under Complaint Number 2677474.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365821	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Creek Nursing Center	5070 Lamme Road Kettering, OH 45439

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, staff interviews, and policy review, the facility failed to accurately monitor and track infections in the facility. This had the potential to affect all 107 residents in the facility. The facility census was 107.Findings include:Review of the Infection Control tracking Logs for June 2025, July 2025, and August 2025 revealed infections were monitored and there was no Coronavirus (COVID-19) or Tuberculosis (TB) in the facility. There were no Infection Control Logs for September 2025, October 2025, November 2025, December 2025 and January 2026.Review of the COVID-19 positive residents dated 11/26/25, revealed there were four residents who tested positive for COVID-19 in November 2025. Interview on 01/08/26 at 9:26 A.M., the Assistant Director of Nursing (ADON) / Infection Preventionist #311 confirmed there were no Infection Control tracking logs or Infection Location surveillance/maps for September 2025, October 2025, November 2025, December 2025, and January 2026. Interview also confirmed that the facility had COVID-19 in late November 2025 and December 2025 and there were no infection control logs available for November or December of 2025 to show the positive cases, and there was no surveillance and contact tracing (facility map) for the COVID-19 positive residents. Interview also confirmed there was no staff education on COVID-19 done at the time of the COVID-19 positive cases. Interview also confirmed there are currently six residents in isolation for wound infections and there is no infection control tracking log for the types of infection.Interview on 01/08/26 at 9:44 A.M. the Director of Nursing (DON) stated when the first case of COVID-19 was detected on 11/23/25, and all staff were notified via what's app and Paycom staff communication system. The DON stated that all the residents were notified in person and all families were notified by phone. Interview also confirmed there is no documentation available for the notifications to staff, residents or families. The DON stated the facility did not have a specific COVID-19 policy, and they followed their COVID-19 Quality Assurance Performance Improvement (QAPI) Plan which indicated the date someone was positive was considered day zero, and that all residents and staff will be tested on days one, three, and five. The DON stated the first positive COVID-19 case was on 11/23/25. The DON stated no additional staff or residents were tested on day one per their QAPI plan. All residents were documented as being tested on days two, four and nine. The DON stated the COVID-19 QAPI Plan indicated if there were additional positive residents between days one and five, then testing would be expanded to twice weekly until no new positives for 14 days. The DON verified the facility's COVID-19 QAPI Plan was not followed and verified there was no documented evidence of the staff being tested for COVID-19. The DON stated the only documentation the facility had of the COVID-19 positive residents was a log that was emailed to the local health department. Review of the COVID-19 QAPI Plan, undated revealed the facility would notify all staff, residents, and families. All staff would have COVID-19 education at the time of a positive case. All residents and staff would be tested on days one, three, and five, and the initial positive test date is day zero. If there were additional positive residents between days one and five of testing, then the testing expanded to twice weekly until no new positives for 14 days.This deficiency represents non-compliance investigated under Complaint Number 2677474.