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	02/25/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and policy review, the facility failed to provide skin assessments, wound treatments and wound measurements were completed in a timely manner. This affected two (#13 and #15) of three residents reviewed for pressure ulcer. The facility census was 110. Findings include: 1.Review of medical record for Resident #13 revealed an admission date of 11/11/25. The resident was admitted with diagnoses including Alzheimer's disease, Diabetes Mellitus, anxiety, atherosclerotic heart disease and hypertension. The resident remained in the facility. The admission Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of five indicating impaired cognition. He required set up for eating, maximum assistance with bed mobility, transfers and was dependent upon staff for toileting hygiene. No pressure ulcers were documented. A care plan initiated 11/18/25 documented a risk for skin alteration related to impaired mobility with interventions which included to inform family, resident and physician of ant new skin breakdown, pressure reducing mattress and weekly skin checks. A behavioral care plan initiated 11/18/25 documented he would put himself on the floor for comfort measures interventions were to offer diversional activities and offer support and reassurance as needed. A Braden Scale (for predicting pressure ulcer risk) completed on 11/11/26 revealed he a score of 16 indicating he was at risk. Record review revealed no skin assessments were documented after the admission assessment until 01/07/26. The 01/07/26 skin assessment documented a right heel pressure area. No measurements were documented. The comment section documented Resident #13 was added to the wound round list for further assessment and treatments. Record review of the 01/07/26 wound documentation revealed a right heel Unstageable Deep Tissue injury (DTI) with intact skin. Measurements were documented as 2.0 centimeters (CM) by (x) 2.0 cm x not measurable. Treatment was to apply betadine daily and as needed. Review of the physician orders revealed an order to cleanse the right heel, pat dry and paint with betadine every night shift and as needed with a start date of 01/14/26. An order for moon boots bilaterally while in bed as tolerated with a start date of 01/14/26. Review of the 01/14/26 wound documentation revealed the wound measurements were 2.0 cm x 2.0 cm x not measurable. The wound progress was documented as improved as evidenced by decreased pain. Record review of the January Treatment Record (TAR) revealed the moon boots bilaterally while in bed as tolerated was documented as completed as expected from 01/14/26. The right heel wound treatment was documented as completed as expected with a start date of 01/15/26. Interview on 01/25/26 at 1:15 P.M. with the Director of Nursing (DON) verified skin assessments had not been completed weekly as care planned for Resident #13 and the treatment orders for the right heel DTI ordered on 01/07/26 had not been placed and initiated until 01/15/26. 2. Review of medical record for Resident #15 revealed an admission date of 12/12/25. The resident was admitted with diagnoses including Diabetes Mellitus Type Two, gout, Congestive Heart Failure (CHF) and depression. The resident remained in the facility. The 5-day Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14 indicating intact cognition. He required moderate assistance with meals, and was dependent upon staff for toileting hygiene, bed mobility and transfers were not attempted. One stage two and one DTI which were documented as present on admission. The readmission skin assessment dated [DATE] revealed a left heel blister no measurements were documented. Review of the physician orders revealed an order to cleanse the left heel with wound cleanser, apply foam border dressing one time a day with a start date of 01/12/26. Review of the January TAR revealed the right heel wound treatment was documented as completed as expected starting on 01/12/26. Review of the 01/14/26 rounding wound documentation revealed the visit had to be rescheduled. Record review of the 01/20/26 progress note revealed the large blister on the left heel began to pop and seep fluids. Resident #15 complained of pain and requested to be sent out for further evaluation. Interview on 01/25/26 at 1:15 P.M. with the DON verified no measurements were taken of the large left heel blister upon Resident #15's readmission to the facility on [DATE] through 01/20/26 when he was sent to the hospital for further evaluation. Review of the facility policy titled, Pressure Injury Risk Assessment dated 08/24 revealed skin would be observed routinely throughout the residents stay and preventative care plans would be implemented. This deficiency represents non-compliance investigated under Complaint Number 2726113.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and policy review, the facility failed to ensure medications were given as ordered. This affected one (#19) of four residents observed for medication administration. The facility census was 110. Findings include: Review of medical record for Resident #19 revealed admission date of 1/9/26. The resident was admitted with diagnoses including Parkinson's disease, right femur fracture and hypertension. The resident remained in the facility. The admission Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of seven indicating impaired cognition. He was independent with eating, required supervision for bed mobility, moderate assistance for transfers and maximum assistance toileting hygiene. Review of the physician orders revealed an order for two Senna Plus (laxative/stool softner) tablets with a start date of 01/10/26. Observation on 01/24/26 at 9:34 A.M. of medication administration for Resident #18 by Licensed Practical Nurse (LPN) #111 revealed she administered an 81 milligram (mg) chewable aspirin, Miralax (laxative) 17 grams, Ropinirole (Parkinson's) one mg, cabidopa/levodopa (Parkinson's) 25 mg/100 mg, Vitamin D (supplement) 25 micrograms (mcg), Amlodipine (high blood pressure) and two Senna (laxative) 8.6 milligram tablets. Interview on 01/10/26 on10:18 A.M. with LPN #111 verified she had given Senna tablets instead of the prescribed Senna Plus tablets. Review of the facility policy titled , Administering Medications dated 04/28/25 documented medications must be administered in accordance with orders. This deficiency represents non-compliance investigated under Complaint Number 2735702.