

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER Oak Creek Terrace Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 Springmill Road Kettering, OH 45440	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to implement a baseline care plan within 48 hours and have fall interventions in place. This affected one (#58) of three residents reviewed for falls. The facility census was 64. Findings include: Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included other displaced fracture of upper end of right humerus, subsequent encounter for fracture with routine healing, chronic kidney disease, and anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #58 had moderately impaired cognition, dependent with toileting and bathing, uses wheelchair for mobility. Review of the admission assessment dated [DATE] for Resident #58 revealed fall risk. Review of the medical record for Resident #58 revealed falls on 03/20/26, 03/27/26, 03/27/26 and 04/10/26. Review of the care plan dated 03/24/26 revealed Resident #58 is at risk for falls and interventions were initiated. Interventions included mats at bedside with bed in lowest position, call don't fall sign, non-skid socks, basic needs being met, physical therapy and occupational therapy, follow fall protocol if an incident occurs, monitor for change in mental status and proper footwear when out of bed. Review of the baseline care plan dated 04/05/26 for Resident #58 revealed fall risk interventions encourage call light for assistance with activities of daily living and transfers. Interview on 04/24/26 at 11:02 A.M. with MDS Coordinator #1 confirmed the baseline care plan for Resident #58 was not completed until 04/06/26 with fall interventions. The MDS Coordinator #1 also verified no fall interventions were documented as in place on admission. Review of the policy titled, Baseline Care Plan, dated 02/2021, revealed the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality of care. The baseline care plan will be developed within 48 hours of a resident's admission. This deficiency represents non-compliance investigated under Complaint Number 2969213.</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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure fall prevention interventions were being followed. This affected one (#60) of three residents reviewed for falls. The facility census was 64. Findings include: Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses included cerebral atherosclerosis, pulmonary fibrosis, chronic kidney disease, and repeated falls. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #60 had severe cognitive impairment, was dependent with bathing and toileting. Review of the care plan dated 03/13/26 for Resident #60 revealed at risk for falls with interventions including bilateral fall mats while in bed. Review of the medical record for Resident #60 revealed falls on 03/09/26, 03/13/26 times two, 03/14/26 times two, 03/22/26 times two, 03/24/26, 03/26/26, and 03/27/26. Observation on 04/24/26 at 10:34 A.M. of Resident #60 lying in bed in her room with no fall mats on either side of the bed or in Resident #60's room. Interview on 04/24/26 at 10:35 A.M. with Licensed Practical Nurse (LPN) #2 confirmed Resident #60 lying in bed in her room with no fall mats on either side of the bed. LPN #2 confirmed Resident #60's care plan has fall mats bilaterally on floor while on bed. Further interview with LPN #2 confirmed the fall mats were not in Resident #60's room all day today and cannot remember the last day LPN #60 saw the fall mats in Resident #60's room. Interview and observation on 04/24/26 at 10:54 A.M. with the Environmental Director (ED) #3 revealed the ED#3 placing the fall mats in Resident #60's room. The ED #3 revealed the fall mats are only removed from resident's rooms when ordered. Interview on 04/24/26 at 12:06 P.M. with the MDS coordinator #1 confirmed the fall mats are in the care plan for Resident #60. Review of the policy titled, Fall Management, dated 01/2021, revealed provide interventions that address unique risk factors measured by the risk assessment tool. This deficiency represents non-compliance investigated under Complaint Number 2969213.</p>		