

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Walnut Hills Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4748 Olde Pump Street Walnut Creek, OH 44687	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and review of the laundry check-list, the facility failed to ensure the dryer lint vents were free from build up. This had the potential to affect all residents residing in the facility. The facility census was 38. Findings include: An observation on 06/25/26 at 8:12 A.M. revealed an empty dryer with the lint trap screen covered with large amount of lint build-up. Further observation revealed lint build-up on the bottom of the dryer below the lint trap screen. An interview on 06/25/26 at 8:14 A.M. with Laundry Staff (LS) #218 verified the lint build up on the lint screen and in the bottom of the dryer. LS #218 stated the dryer lint trap screens were cleaned at the end of each shift. An interview on 06/25/26 at 10:15 A.M. with the Administrator revealed the facility had no policy to review concerning dryer lint trap cleaning. Review of the facility's laundry checklist revealed laundry staff were responsible at the end of each shift to clean the lint trap screens for the dryers.		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure the Advanced Directive code status was consistent throughout the medical record. This affected two (#7 and #19) of two residents reviewed for code status, with the potential to affect all residents except for six (#6, #15, #16, #28 and #43) who were identified as having a full code status. The facility census was 38. Findings include: 1. Review of Resident #19's medical record revealed an admission date of [DATE], with a diagnosis of chronic systolic congestive heart failure. Review of the care plan initiated [DATE] revealed Resident #19 had a Do Not Resuscitate Comfort Care (DNRCC - aggressive or invasive medical interventions are stopped right away) code status. Interventions included to ensure direct care staff knew the code status. Review of Resident #19's paper medical record revealed a red paper at the front of the chart indicating the resident had a Do Not Resuscitate (DNR - do not perform cardiopulmonary resuscitation [CPR] but continue other routine treatments) code status. Further review of the Advanced Directives section revealed a form titled, DNR Order Form dated [DATE]. Resident #19's name was printed at the top of the form, and it was signed by the resident's representative. The form had two options to choose from, Do Not Resuscitate Comfort Care Arrest (DNRCC-A) (full, aggressive treatments continue until the heart or breathing completely stops) and the second option was DNRCC. The DNRCC-A box was marked with an X and signed by Certified Nurse Practitioner (CNP) #600. Review of the physician order dated [DATE] revealed Resident #19 had an order for a DNRCC code status. Interview on [DATE] at 3:01 P.M. with Licensed Practical Nurse (LPN) #601, and concurrent review of Resident #19's paper medical record, confirmed the red page, upon opening the record, revealed the resident had a DNR only code status. Further interview and review of the paper medical record confirmed Resident #19 had a DNRCC-A code status located under the Advanced Directives section and the physician order in the electronic medical record (EMR) showed the resident had a DNRCC code status. When asked which order should be followed, LPN #601 hesitated and revealed she was an agency nurse and would likely follow the physician order in the EMR. Interview on [DATE] at 3:04 P.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #264 confirmed Resident #19's code status was not clear, the Advanced Directives did not match the order documented, and the red form in front of the chart was not clear or complete to determine DNRCC or DNRCCA. The DON confirmed there was a difference in the care provided for residents with a DNRCC and a DNRCC-A code status that could make a difference between life and death. ADON #264 stated all residents, who were not a full code status, had the red paper in the paper medical record that indicated DNR code status but confirmed the document did not specify if the resident had a DNRCC or DNRCC-A code status. 2. Review of Resident #7's medical record revealed an admission date of [DATE]. Diagnoses included dysarthria and anarthria. Review of Resident #7's paper medical record revealed a red paper at the front of the record indicating the resident had a DNR code status. Further review of the Advanced Directives section revealed a form titled, DNR Order Form dated [DATE]. Resident #7's name was printed at the top of the form and was signed by the resident. Physician #603 signed the document on [DATE]. Further review revealed Resident #7's code status was DNRCC-A. Interview on [DATE] at 2:52 P.M. with LPN #256 revealed if she needed to find a resident's code status, she would use either the paper medical record or the EMR, depending on which was closer to get to. Interview on [DATE] at 3:06 P.M. with the DON confirmed Resident #7's code status was not clear, with the red form in the front of the paper medical record showing DNR but not specifying if the resident was a DNRCC or a DNRCC-A code status.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were not left at a resident's bedside and further failed to ensure medications were not expired. This affected one (#21) of five residents reviewed for medication administration. Additionally, the facility failed to ensure medications were not left unattended and unsecured on a medication cart. This had the potential to affect 10 (#5, #12, #14, #19, #21, #22, #18, #31, #33, and #36) residents identified by the facility as being independently mobile. The facility census was 38. Findings include: 1. Record review for Resident #21 revealed an admission date of [DATE]. Diagnoses included Parkinson's disease, nonexudative age-related macular degeneration left eye, intermediate dry stage, nonexudative age-related macular degeneration right eye advanced atrophic without sub foveal involvement and dry eye syndrome of bilateral lacrimal glands. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact and had impaired vision. Review of the care plan initiated [DATE] revealed Resident #21 had impaired visual function related to diagnosis of right eye end stage macular degeneration and moderate macular degeneration in the left eye, hypertensive retinopathy, and a history of dry eye syndrome. Further review of Resident #21's care plan revealed no documentation of self-administration of eye drops. Review of the current physician orders revealed Resident #21 had an order for Systane Ultra, instill one drop in both eyes two times a day related to dry eye syndrome of bilateral lacrimal glands. Further review revealed no physician order for the self-administration of eye drops. Observation on [DATE] at 8:40 A.M. during medication administration with Medication Aid (MA) #519 revealed Resident #21 had two vials of Visine eye drops on the bedside table next to the resident. Further observation revealed the expiration date on one partially used vial was [DATE] and the second vial expired [DATE]. MA #519 verified both vials of Visine eye drops were expired. Concurrent interview with Resident #21 confirmed she still used both vials occasionally as needed. MA #519 exited the room without removing the vials. Interview on [DATE] at 8:50 A.M. with Licensed Practical Nurse (LPN) #325 verified Resident #21 was unable to self-administer her own eye drops. LPN #325 stated that a long time ago, Resident #21 was able to administer her own eye drops but since her decline, she could and should not have eye drops left in her room. 2. Observation on [DATE] at 9:17 A.M. of the long-term care medication cart revealed an unopened lidocaine four percent (%) pain relief patch lying on top of the medication cart, with no nursing staff visible in the area. Continued observation revealed at 9:20 A.M., visitors were conversing near the medication cart and additional non-nursing staff and residents passed near the medication cart. Interview and concurrent observation on [DATE] at 9:23 A.M. with the Director of Nursing (DON) verified the lidocaine patch was left unsecured on the medication cart. The DON confirmed medications should not be left unattended on the medication carts.		

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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 medical record review, review of a facility Self-Reported Incident (SRI), resident and staff interviews and review of facility policy, the facility failed to ensure allegations of abuse were thoroughly investigated. This affected one (#24) of three residents reviewed for abuse. The facility census was 38. Findings include: Review of Resident #24's medical record revealed an admission date of 06/23/22. Diagnoses included multiple sclerosis and unspecified psychosis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was mildly cognitively impaired. Resident #24 had impairment on both sides of the upper and lower extremities and required assistance with activities of daily living (ADLs). Resident #24's hearing was adequate, made self-understood, was able to understand others. Resident #24 had no hallucinations or delusions. Review of the facility initiated SRI, dated 06/05/26, revealed the charge nurse on the North Unit, where Resident #24 resided, received a call from his brother at approximately 9:20 P.M. on 06/05/26. He stated his mother, who had been visiting the resident earlier that evening, returned home and called him to tell him that the resident told her that he had been raped the day before. The Administrator was notified. The charge nurse performed a full assessment of the resident and there was no sign of trauma or injury. The Administrator called the resident's mother upon arriving at the facility to confirm what she had told her other son. The resident was interviewed by the Director of Nursing (DON) and the Administrator, and he stated that a woman, who he had never seen before, came into his room the previous day, had her way with me, and left the room without saying a word. When questioned, he stated that he was in bed for the night, not in his recliner, and that it was before it got dark. The resident was unable to give a description. Staff were interviewed and stated they did not see anyone in the facility that they did not know or recognize. The allegation was unsubstantiated. Review of the staff schedule for 06/04/26 revealed 12 staff, including Certified Nursing Assistant (CNA) #234, CNA #317, CNA #420, Licensed Practical Nurse (LPN) #515, Culinary Aid (CA) #222, CA #604, [NAME] #335, CNA #226, CNA #240, CNA #323, CNA #361 and LPN #212 were working during the time of the alleged sexual abuse. Interview on 06/24/26 at 2:46 P.M. with the Administrator and the DON, and concurrent review of the facility investigation, revealed four staff members (CNA #234, CNA #317, CNA #420, and LPN #515) were interviewed during the facility investigation. The DON revealed she completed the staff interviews, and she determined the time frame must have been between dinner and bedtime, so around 5:00 P.M. to 7:30 P.M., because Resident #24's mother visited that day until right before dinner and the resident said it was still light outside when the rape occurred. The Administrator confirmed eight (CA #222, CA #604, [NAME] #335, CNA #226, CNA #240, CNA #323, CNA #361 and LPN #212) were working the evening of 06/04/26 and were not interviewed as part of the facility investigation. The Administrator verified that all staff who were present in the facility at the time of the alleged sexual abuse were not interviewed but should have been. Interview on 06/24/2026 at 4:32 P.M. with Resident #24 revealed the resident alleged he was raped by a female on 06/04/26. The resident stated it was daylight outside at the time of the alleged incident. Resident #24 stated he did not know if the female was a staff or not, adding he never met dietary staff or most of the housekeeping staff and he did not know all of the nurses or CNAs. Resident #24 was unable to provide a description of the female. Review of the facility policy titled, Abuse Investigation Protocol, revised April 2024, revealed the facility investigation included identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation.		

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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, observation and interview, the facility failed to ensure physician ordered treatments were completed by licensed nursing staff. This affected one (#28) of three residents reviewed for quality of care. The facility census was 38. Findings include: Review of Resident #28's medical record revealed an admission date of 11/22/24, with diagnoses including cellulitis of the left lower limb. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact, had impairment on both sides of the upper and lower extremities and required assistance with activities of daily living (ADLs). Resident #28 had no pressure ulcers, wounds or skin concerns. Review of the care plan revised 06/17/26 revealed Resident #28 had the potential for impairment to skin integrity related to a history of sepsis, bilateral lower extremity cellulitis and lymphedema. Interventions included following the facility protocol for treatment of injury and monitor the wound for signs and symptoms of infection (redness, drainage, swelling, warmth) and report changes promptly. Review of a physician order dated 10/14/25 revealed to apply Ace wraps to Resident #28's bilateral lower legs in the morning one time a day for edema. Further review of the Treatment Administration Record (TAR) for June 2026 revealed licensed nursing staff signed off on the TAR daily indicating the treatment was completed. Review of the History and Physical report dated 06/24/26 and authored by Certified Nurse Practitioner (CNP) #605 revealed Resident #28 presented after hospitalization from 06/07/26 to 06/15/26 for diagnoses which included septic shock due to Streptococcus agalactiae bacteremia with left lower extremity cellulitis. The Assessment and Plan included to continue oral penicillin as per infectious disease recommendations and monitor for any signs of recurrent infection. Observation on 06/25/26 at 10:20 A.M. revealed Resident #28 was sitting up in her chair in her room. Concurrent interview with Certified Nursing Assistant (CNA) #220 revealed she just completed morning care for Resident #28 and was going to apply the resident's Ace wraps to her bilateral lower legs. CNA #220 revealed she normally applied Resident #28's Ace wraps on the days she worked and further revealed she was never trained on the proper application of the Ace wraps. Continued observation revealed Resident #28's bilateral lower extremities were swollen, and both were discolored. Interview on 06/25/26 at 11:04 A.M. with the Director of Nursing (DON) verified the licensed nurse should apply Ace wraps because it was out of the scope of practice for CNAs to do. The DON further stated the licensed nurse would need to apply the Ace wraps to Resident #28's lower extremities in order to monitor the resident's legs due to recent sepsis/cellulitis.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews and review of facility policy, the facility failed to implement non-pharmacological interventions prior to the administration of pain medications. This affected one (#11) of five residents reviewed for unnecessary medication. The facility census was 38. Findings include: Review of Resident #11's medical record revealed an admission date of 04/24/23 with diagnoses including, but not limited to, chronic pain, anxiety, depression, and chronic respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 has a pain program and received scheduled and as needed pain medication without non-pharmacological interventions used. Review of Resident #11's physician orders revealed an order dated 04/01/25 for oxycodone 10 milligram (mg), give one tablet by mouth every two hours as needed (PRN) for pain. Review of the Medication Administration Record (MAR) for June 2026 revealed on 06/03/26 at 2:06 A.M., Resident #11 received PRN oxycodone 10 mg for pain, with no non-pharmacological interventions implemented prior to medication administration. Further review revealed on 06/15/26 at 10:44 A.M., Resident #11 received PRN oxycodone 10 mg for pain, with no non-pharmacological interventions implemented prior to medication administration. Review of Resident #11's progress notes from 06/01/26 to 06/24/26 revealed no evidence that non-pharmacological interventions were attempted prior to PRN pain medication being administered. Interview on 06/24/26 at 7:40 A.M. with Licensed Practical Nurse (LPN) #325 revealed non-pharmacological interventions were implemented and documented in the MAR progress notes prior to administration of PRN pain medications. Interview on 06/24/26 at 9:55 A.M. with the Director of Nursing (DON) verified Resident #11 did not have any pain non-pharmacological interventions implemented prior to the administration of PRN pain medication. The DON stated non-pharmacological interventions were implemented as of 06/24/26. Review of the facility policy titled, Pain - Clinical Protocol, dated 02/11/26, revealed the physician would order appropriate non-pharmacologic and medication interventions to address the individual's pain.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of facility policy, the facility failed to ensure enhanced barrier precautions (EBP) were followed during wound care. This affected one (#23) of three residents reviewed for transmission-based precautions (TBP). The facility census was 38. Findings include: Review of Resident #23's medical record revealed a readmission date 04/30/26 with diagnoses including, but not limited to, heart disease, epilepsy, vascular dementia, and anxiety. Review of the significant change [NAME] Data Set (MDS) assessment dated [DATE] revealed Resident #23 had severe impaired cognition and was dependent on staff for all Activities of Daily Living (ADLs). Review of Resident #23's physician orders revealed orders dated 06/16/26 to cleanse the right outer heel with saline, pat dry, apply Alginate, cover with foam dressing, and change three times a week and as needed (PRN) in the morning every Tuesday, Thursday, Saturday for wound care and as needed for soiling or lifting and apply Triad paste to the right hallux tip (big toe) daily in the morning for wound care and as needed for skin irritation. Further review revealed an order dated 06/18/26 for EBP related to wounds. Review of the care plan, revised 06/18/26, revealed Resident #23 was on EBP related to wounds. Observation on 06/23/26 from 10:12 A.M. to 10:30 A.M. revealed Registered Nurse (RN) #319 and Certified Nurse Practitioner (CNP) #550 entered Resident #23's room to complete wound care for the right outer heel wound and the right hallux tip wound. On the door of Resident #23's was notification signage for EBP. Continued observation revealed RN #319 and CNP #550 washed their hands and placed gloves on but did not don a gown. RN #319 removed the soiled dressing from Resident #23's right outer heel and cleansed the area with saline. CNP #550 measured the area and RN #319 placed the new dressing. RN #319 removed the gloves and washed her hands prior to exiting the resident's room. Interview on 06/23/26 at 10:40 A.M. with RN #319 verified neither she nor CNP #550 donned a gown prior to completing Resident #23's wound care. RN #319 stated her understanding of EBP was for chronic wounds. RN #319 stated Resident #23's wounds were not chronic, therefore EBP were not followed during wound care. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 06/12/25 revealed high - contact resident care activities included wound care, defined as any skin opening requiring a dressing.		