STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365639	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINGSTON OF VERMILION	4210 TELEGRAPH LANE VERMILION, OH 44089

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, review of the facility's self-reported incidents, review of the facility's policy, the facility failed to report allegations of abuse to the State Survey Agency. This affected five (#2, #13, #30, #62 and #96) of five residents reviewed for abuse. The facility census was 99. Findings include 1. Medical record review for Resident #13 revealed the resident had an admitted d of 09/04/19. [DIAGNOSES REDACTED]. Review of the of the admission Minimum Data Set (MDS) assessment, dated 09/13/19, revealed the resident had severe cognitive impairment. Medical record review for Resident #62 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/27/20, revealed the resident had impaired cognition. Review of an incident witness statement, dated 09/15/19, revealed at about 3:00 P.M., Resident #62 sat in the hallway yelling at Resident #13 telling her she is not cured, and she should be locked up somewhere. Resident #62 told Resident #13 my son will get you. Review of a second incident witness statement, dated 09/15/19, revealed Resident #62 was sitting in the hallway making threatening comments to Resident #13. Resident #62 stated she was going to take her water cup and hit Resident #13 if she came out of her room or near her. Resident #13 was scared to come out of her room. The two residents were separated. Review of the facility's self-reported incidents from 09/15/19 to 03/02/20 revealed the facility did not report the allegation of resident-to-resident abuse the occurred on 09/15/19. Interview on 03/04/20 at 5:08 P.M. with the Administrator verified the incident between Resident #62 and Resident #13 had not been reported to the State Survey Agency as required. 2. Medical record review for Resident #30 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/03/20, revealed Resident #30 had impaired cognition. Review of a nurse's note, dated 01/12/20, revealed Resident #30 reported to the nurse, Resident #13 came up behind her in the hallway and pushed her wheelchair. When Resident #30 told Resident #13 to stop pushing her, Resident #13 then hit Resident #30 on the left shoulder and right arm. The Director of Nursing was notified. Review of an incident witness statement, dated 01/31/20, revealed Resident #30 was trying to pass through a doorway which was blocked by Resident #13. Resident #30 asked Resident #13 to move. Resident #13 grabbed Resident #30's arm. Resident #30 pulled her arm away and told Resident #13 Don't touch me. Resident #30 stated I want to report her every time she touches me. The Administrator was notified of the incident. Review of the facility's self-reported incidents from 01/12/20 to 03/02/20 revealed the facility did not report the allegation of resident-to-resident abuse the occurred on 01/12/20 and 01/31/20. Interview on 03/04/20 at 10:58 A.M. with the DON revealed on 01/12/20 Resident #30 alleged Resident #13 pushed her then hit her. Interview on 03/04/20 at 11:11 A.M., the Administrator verified the incidents on 01/12/20 and 01/31/20 between Resident #30 and Resident #13 were not reported to the State Survey Agency. Interview on 03/04/20 at 2:53 P.M. with Registered Nurse (RN) #10 revealed on 01/12/20, Resident #30 reported Resident #13 had hit her. RN #10 revealed she reported the incident to the Director of Nursing. Interview on 03/05/20 at 10:50 A.M. with Resident #30 revealed another resident with dementia picked on people. Resident #30 stated the resident ran into her, pulled on her wheelchair and hit her on two different days. Resident #30 revealed she reported both incidents to her nurse. 3. Medical record review for Resident #96 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 02/10/20, revealed the resident had impaired cognition. Review of a nurse's note, dated 01/23/20 at 8:55 A.M., revealed Resident #13 was observed striking another resident's leg with her baby doll, unprovoked. Review of the facility's self-reported incidents from 01/23/20 to 03/02/20 revealed the facility did not report the allegation of resident-to-resident abuse the occurred on 01/23/20. Interview on 03/05/20 at 10:56 A.M. with Resident #96 revealed Resident #13 had punched him in the leg a while ago. Interview on 03/05/20 at 10:59 A.M. with the Staffing Coordinator (SC) #107 revealed on 01/23/20 she was coming up the hallway and saw Resident #13 hit Resident #96 with a baby doll with a plastic head. SC #107 revealed Resident #13 hit Resident #96 hard and she got right between them to separate them. SC #107 reported the incident to the resident's nurse. Interview on 03/05/20 at 11:03 A.M. with the Staff Development Nurse (SDN) #197 revealed Resident #13 hit Resident #96 with her doll. SDN #197 revealed the residents were separated. SDN #197 revealed she reported the incident to the Administrator. Interview on 03/05/20 at 12:05 PM with the Administrator and Director of Nursing verified the incident on 01/23/20 between Resident #13 and Resident #96 was not reported to the State Survey Agency as required. 4. Medical record review for Resident #2 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 11/14/19, revealed Resident #2 had intact cognition. Review of a documented interview, dated 03/03/20 at 4:45 P.M., revealed Resident #2 told the Licensed Social Worker (LSW) #196 that Resident #13 had hit him in the arm. Resident #2 revealed he had not reported the incident at the time it had occurred. Interview on 03/02/20 at 10:53 A.M. with Resident #2 revealed Resident #13 had hit him six months ago and had hit other residents in shoulder. Interview on 03/05/20 at 10:39 A.M. with Licensed Social Worker (LSW) #196 revealed on 03/03/20, Resident #2 stated Resident #13 hit him either when he first got here or three to four months ago. Interview on 03/05/20 at 11:12 A.M. with the Administrator stated she just reported the allegation made by Resident #2 on 03/03/20. The Administrator verified the allegation was not reported to State Survey Agency within 24 hours as required. Review of the facility's policy titled Abuse Reporting-Staff treatment of [REDACTED].
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, the facility failed to provide written notification of the resident's transfer to the hospital to the resident and/or resident's representative and to the Office of the State Long-Term Care Ombudsman. This affected two (Resident #95 and #100) of two residents reviewed for hospitalization . The facility census was 99. Findings include: 1. Review of Resident #95's medical record revealed an admission to the facility on [DATE]. Resident #95 was hospitalized from [DATE] through 02/14/20 and was readmitted back to the facility at that time. The record lacked any evidence Resident #95's family was provided any written evidence of the reason for the hospital discharge. There was no evidence the Office of the State Long-Term Care Ombudsman was notified of Resident #95's transfer to the hospital. Interview with the Administrator on 03/04/20 at 1:07 P.M. stated the facility receptionist should be completing the written notifications and confirmed they were not completed for Resident #95's hospitalization on [DATE]. He stated the facility completed an audit and identified this occurred because the receptionist was sick and they did not have any others.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 2. Review of the medical record for Resident #100 revealed an admission date of [DATE] and discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the discharge summary note dated 12/04/19 revealed Resident #100 discharges to emergency department for medical evaluation. There was no evidence in the medical record a written notification of the resident's transfer to the hospital was provided to the resident and the resident's representative. Interview on 03/05/20 at 8:50 A.M. with the Administrator verified Resident #100 or representative did not receive the written notification of the resident's transfer to the hospital.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the Ohio and Federal Nursing Home Residents' Bill of Rights handbook and review of the facility's policy, the facility failed to provide a notice to the resident and/or resident's representative of the facility's bed hold policy upon the resident's discharge to the hospital. This affected two (#95 and #100) of two residents reviewed for hospitalization . The facility census was 99. Findings include: 1. Review of the medical record for Resident #100 revealed an admission date of [DATE] and discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the discharge summary note, dated 12/04/19, revealed Resident #100 was discharged to the emergency department for medical evaluation. There was no evidence in the resident's medical record the resident and/or resident's representative was given notice of the facility's bed hold policy upon the resident's discharge to the hospital. Interview on 03/05/20 at 8:50 A.M. with the Administrator verified the facility did not provide written notice of the facility's bed hold policy to Resident #100 and/or representative at the time of transfer to the hospital. 2. Review of Resident #95's medical record revealed an admission to the facility occurred on 08/07/19. Resident #95 was hospitalized from [DATE] through 02/14/20 and was readmitted back to the facility at that time. There was no evidence in the resident's medical record the resident and/or resident's representative was given notice of the facility's bed hold policy upon the resident's discharge to the hospital. Interview with the Administrator on 03/04/20 at 1:07 P.M. confirmed there was no bed hold notification information provided to Resident #95's family at the time of his transfer to the hospital on [DATE]. Review of the facility's policy titled Bed Hold, Transfer,and Discharge Notice, dated 09/2018, revealed a bed hold notice is also required at the time of transfer or, in case of an emergency with in 24 hours. Review of the Ohio and Federal Nursing Home Residents' Bill of Rights handbook, dated 02/01/18, provided to all residents revealed at the time of transfer of a resident for hospitalization , the facility must provide the resident and the resident's representative written notice which specified the duration the bed-hold policy.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the Resident Assessment instrument (RAI) manual and staff interviews, the facility failed to ensure the residents had accurate Minimum Data Set (MDS) assessments. This affected 11 (Resident #4 #14, #16, #18, #23, #26, #40, #59, #60, #67 and #77) of 32 resident reviewed for MDS assessments. The facility census was 99. Findings include: 1. Review of Resident #18's medical record revealed an admission to the facility occurred on 10/24/19. Review of the Minimum Data Set (MDS) assessment, dated 02/01/20, revealed in section C, for the Brief Interview for Mental Status (BIMS) (test of the cognition function), it was marked as not assessed. 2. Review of Resident #40's medical record revealed an admission to the facility occurred on 10/12/19. Review of the MDS assessment, dated 01/09/20, revealed section C was marked as not assessed. 3. Review of Resident #67's medical record revealed an admission to the facility occurred on 07/12/13. Review of the MDS assessment, dated 01/23/20, revealed section C was marked as not assessed. 4. Review of Resident #77's medical record revealed admission to the facility occurred on 10/25/19. Review of the MDS assessment, dated 02/21/20, revealed section C was marked as not assessed. 5. Medical record review for Resident #23 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/23/20, revealed section C was marked as not assessed. 6. Medical record review for Resident #14 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 12/18/19, revealed section C was marked as not assessed. 7. Medical record review for Resident #16 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the significant change MDS assessment, dated 12/19/19, revealed section C was marked as not assessed. 8. Medical record review for Resident #60 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. 9. Medical record review for Resident #26 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. 10. Medical record review for Resident #4 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. 11. Record review for Resident #59 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Interview on 03/03/20 at 2:42 P.M. with the MDS Nurse #17 verified the BIMS assessments were not completed and the resident's cognition status was not assessed. Interview with Registered Nurse (RN) #17 on 03/03/20 at 2:45 P.M. revealed as of 10/01/19 the therapy department was responsible for completing section C of the MDS. The interview revealed in 01/2020 it was determined there were many missing assessments and the therapy director was notified. Interview with Speech Therapist/Rehabilitation Director #156 on 03/04/20 at 7:54 A.M. confirmed therapy started completing section C of the MDS in 10/2019. The interview revealed in January 2020 they revealed the assessments were not getting completed timely and provided some education to the staff. The interview confirmed the assessments were still not getting completed timely so the education apparently did not work.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure the restorative nursing was implemented for Resident #47. This affected one (#47) of two residents reviewed for limited range of motion and mobility. The facility census was 99. Findings include: Review of Resident #47's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 10/08/19, revealed the resident had upper extremity impairment on both sides and no impairment on the lower extremity. Further review of the resident's medical revealed Resident #47 was readmitted to the facility following hospitalization on [DATE]. She received physical therapy (PT) and occupational therapy (OT) from 01/05/20 until she was discharged from therapy on 01/23/20. Review of the PT/OT discharge summaries, dated 01/23/20, revealed the recommendations were to continue with Stand Pivot Transfer (SPT) with pivot disc, two person assistance in and out of bed, a stand up lift on and off the toilet, and restorative nursing program for lower extremity active assistance range of motion to prevent further knee flexion contracture. The OT discharge summary, also dated 01/23/20, recommended restorative dining with one-person assistance to ensure proper nutritional intake. Review of the facility's order summary report, dated 01/27/20, revealed orders for Resident #47 to receive transfers via stand-up lift with one-person assistance on and off toilet and SPT using pivot disc on and off bed with two-person assistance every shift. The order date was 01/23/20 and the start date was also 01/23/20. Interview with Resident #47 on 03/02/20 at 2:37 P.M. revealed her knees were problematic and cause pain. She stated that she walks behind her wheelchair short distances with assistance. Interview on 03/04/20 at 7:56 A.M. with Physical Therapist (PT) #183 confirmed upon discharge, Resident #47 was referred for restorative nursing program. Interview on 03/04/20 at 12:57 P.M. with the Administrator and the DON confirmed the restorative program was not established based on the therapy recommendations from 01/23/20.
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.**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review and staff interview, the facility failed to implement fall interventions for one (Resident #18) of three residents reviewed for falls. The facility census was 99. Findings include: Review of Resident #18's medical record revealed an admission to the facility occurred on 03/13/18. The assessment, dated 12/21/19, identified Resident #18 to be at a high risk for falling and a written plan of care was developed. Review of the resident's fall care plan, dated 12/2019, revealed interventions including for fall mats to both sides of the resident's bed and pad an protect the side rails. Review of the physician orders, dated March 2020, revealed orders for fall interventions of mats on bilateral sides of Resident #18's bed and padded side rails. Observations of Resident #18 on 03/02/20 at 11:38 A.M. and 2:00 P.M. and on 03/03/20 at 11:10 A.M. revealed he was lying in bed and there was no mat to the left side of the resident's bed or a padded rail to the right side. Interview with the Director of Nursing on 03/03/20 at 2:04 P.M. confirmed Resident #18's physician orders [REDACTED].#18 did not have the floor mat on the left side of the bed or the padded side rail on the right side.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **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 a resident's anchoring device was in place to attempt to prevent accidental trauma, pain or injury from excessive tension or removal of a indwelling catheter. This affected one (Resident #200) of one resident reviewed for catheter care. This facility identified nine residents who had with indwelling catheters. The facility census was 99. Findings include: Review of Resident #200's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the care plan, dated 03/02/20, revealed the resident had an indwelling catheter due to a [MEDICAL CONDITION] bladder and an intervention included to secure the catheter to the thigh or abdomen to avoid urinary tension on urinary meatus and trauma to urethra. The indwelling catheter leg strap was to be applied to the thigh to be used at all times. Observation on 03/04/20 at 1:39 P.M. of catheter care with State tested Nursing Assistant (STNA) #124 and #153 and License Practical Nurse (LPN) #65 revealed Resident #200 was without a leg strap. Interview on 03/04/20 at 1:40 P.M. with License Practical Nurse #65 verfiied the resident was to have a device to secure the indwelling to prevent from accidentally removing the tubing. LPN #65 verified was no anchoring device was in place for Resident #200's indwelling catheter. Review of the facility's policy titled Perineal Care, dated 02/21/18, revealed the purpose of this procedure was to provide cleanliness and comfort to the resident, prevent infections and skin irritation, and to observe the resident's skin condition.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the facility's policy, the facility failed to ensure the resident-to-resident incidents were documented in the medical record. This affected three (#13, #30 and #62) of 32 resident's record reviewed. The facility census was 99. Findings include 1. Medical record review for Resident #13 revealed the resident had an admitted d of 09/04/19. [DIAGNOSES REDACTED]. Review of the of the admission Minimum Data Set (MDS) assessment, dated 09/13/19, revealed the resident had severe cognitive impairment. Medical record review for Resident #62 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/27/20, revealed the resident had impaired cognition. Review of an incident witness statement, dated 09/15/19, revealed at about 3:00 P.M., Resident #62 sat in the hallway yelling at Resident #13 telling her she is not cured, and she should be locked up somewhere. Resident #62 told Resident #13 my son will get you. Review of a second incident witness statement, dated 09/15/19, revealed Resident #62 was sitting in the hallway making threatening comments to Resident #13. Resident #62 stated she was going to take her water cup and hit Resident #13 if she came out of her room or near her. Resident #13 was scared to come out of her room. The two residents were separated. Review of the nurses notes, dated 09/15/19, revealed there was no documentation of the incident in the medical records of Resident #13 and Resident #62. Interview on 03/05/20 at 10:43 A.M. with the Administrator verified all observations and incidents should be documented in the residents' medical record per the facility's policy. Interview on 03/05/20 at 12:05 P.M. with the Administrator and the Director of Nursing (DON) verified the incident was not documented in the residents' medical records. 2. Medical record review for Resident #30 revealed the resident had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/03/20, revealed Resident #30 had impaired cognition. Review of an incident witness statement, dated 01/31/20, revealed Resident #30 was trying to pass through a doorway which was blocked by Resident #13. Resident #30 asked Resident #13 to move. Resident #13 grabbed Resident #30's arm. Resident #30 pulled her arm away and told Resident #13 Don't touch me. Resident #30 stated I want to report her every time she touches me. The Administrator was notified of the incident. Review of the nurses notes, dated 01/31/20, revealed there was no documentation of the incident in the medical record for Resident #13 and Resident #30. Interview on 03/05/20 at 12:05 PM, the Administrator and the Director of Nursing verified the incident was not documented in the residents' medical records. Review of the facility's policy titled Charting and Documentation, dated 04/2014, revealed all services provided to the resident, or any changes in the resident's medical or mental condition shall be documented in the resident's medical record. All incidents, accident or changes in the resident's condition must be recorded.