STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365639	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on Observations, interviews and record review the facility failed to provide privacy during resident care. This affected six (Resident #13, #51, #65, #68, #71, and #106) of 20 residents residing on the memory care unit. Findings include: Review of medical record for Resident #106 revealed an admitted [DATE]. Resident #106 had impaired cognition. Review of medical record for Resident #13 revealed an admitted [DATE]. Resident #13 had impaired cognition. Review of medical record for Resident #15 revealed an admitted [DATE]. Resident #15 had impaired cognition. Review of medical record for Resident #51 revealed an admitted [DATE]. Resident #51 had impaired cognition. Review of medical record for Resident #68 revealed an admitted [DATE]. Resident #68 had impaired cognition. Review of medical record for Resident #74 revealed an admitted [DATE]. Resident #74 had impaired cognition. Observations on 07/18/24 at 9:52 A.M. revealed Podiatrist #152 set up in the dining room/ activity room trimming Resident #106's toenails. Residents #13, #15, #51, #68, and #71 were seated in the room because they also had their toenails trimmed. Interview on 07/18/24 at 9:56 A.M., the Activity Director #151 stated she did not know why the Podiatrist was in the dining room trimming nails. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/18/24 at 10:00 A.M., the Activity Assistant #150 stated Podiatrist #152 trimmed the toenails for four other residents. Observations of the area where the trimming took place revealed toenail clippings approximately a two-by-two-foot area on the floor. The activity assistant verified the findings and stated he should have taken the residents to their room to provide care. Interview on 07/18/24 at 10:14 A.M., Podiatrist #152 stated he was not sure why the facility had him trimming nails in the dining room. The Podiatrist then went on to say it was difficult to bring 15 residents in wheelchairs to their rooms. The deficiency is an incidental findings discovered during the course of a complaint investigation.

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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 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** 35768 Based on record review and interview the facility failed to use a mechanical lift for a transfer for one, (Resident #53) of three reviewed for falls. The facility census was 107. Findings include: Review of medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included unspecified dementia with psychotic disturbance. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/26/24, revealed the resident had impaired cognition. The resident was dependent for bed mobility, transfers, and ambulation. Resident #53 required a mechanical stand-up lift for all transfers. Review of the facility fall risk evaluation dated 06/17/24 revealed Resident #53 was at high risk for falls. The evaluation indicated an Agency State tested Nurse Assistant (STNA) #157 notified Licensed Practical Nurse #154 that Resident #53 was in the shower room and had to be lowered to the floor. Facility staff completed a thorough investigation which reported no injuries. Interview on 07/17/24 at 1:40 P.M., Medication Technician (MT) #155 stated STNA #157 did not use the stand-up lift to transfer Resident #53. MT #155 stated Resident #53 had to be lowered to the floor. Interview on 07/17/24 at 3:45 P.M., Physical Therapist (PT) #156 stated Resident #53 was in the shower room, the agency staff told Resident #53 she would not need the stand-up lift, that she could lift the resident by herself. PT #156 stated Resident #53 always required a stand-up lift for all transfers. Interview on 07/17/24 at 3:58 P.M., Resident #53 stated STNA #157 stated she would not use the stand-up lift because it would take to much time. Resident #53 stated she told STNA #157 that she was taller and bigger than her. Resident #53 stated STNA #157 lifted her by her arms and she slid onto the floor. Resident #53 said STNA #157 should have listened to her. Interview on 07/18/24 at 9:06 A.M., the Director of Nursing (DON) stated STNA #157 did not use the stand-up lift to transfer Resident #53. The DON stated all staff have resident information related to what devices are required to transfer each resident. The DON stated STNA #157 was placed on the do not return, list. This deficiency represents non-compliance investigated under Complaint Number OH00155197.