

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365639	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2025
NAME OF PROVIDER OR SUPPLIER Kingston of Vermilion		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, medical record review, and staff and resident interview, the facility failed to ensure showers were provided to dependent residents as scheduled. This affected two (#72 and #37) of three residents reviewed for showers. Additionally, the facility failed to ensure residents received timely assistance with eating. This affected three (#37, #84, and #65) of three residents reviewed for assistance with eating. The facility identified 21 residents who required staff assistance with eating. The facility census was 99. Findings include: 1. Review of the medical record for Resident #72 revealed an admission date of 06/29/23. Diagnoses included hypertensive heart disease with heart failure, unspecified dementia, and orthostatic hypotension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/14/25, revealed Resident #72 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. This resident was assessed to require setup assistance with showering and bathing. Review of the care plan dated 06/29/23 revealed Resident #72 required assistance with activities of daily living (ADLs) related to lumbosacral spondylosis, impaired mobility, chronic pain, and arthritis. Interventions included assisting with showers twice weekly, or per resident preference. Review of the shower documentation for Resident #72 from 11/24/25 through 12/22/25 revealed a shower was given on 11/24/25, 12/11/25, 12/18/25, and 12/22/25 (four of nine opportunities). Interview on 12/18/25 at 9:43 A.M. with Resident #72 revealed showers were to be given on Mondays and Thursdays. Resident #72 further stated she rarely received a shower on Mondays, due to staff being too busy. Interview on 12/22/25 at 10:55 A.M. with Licensed Practical Nurse (LPN) #212 confirmed there was no evidence Resident #72 was provided showers on 12/01/25, 12/08/25, and 12/15/25 (all Mondays). 2. Review of the medical record for Resident #37 revealed an admission date of 03/29/23. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, dysphagia, and dementia. Review of the quarterly MDS assessment, dated 10/02/25, revealed Resident #37 had impaired cognition as evidenced by a BIMS score of five. Resident #37 was dependent on staff to complete ADL care. Review of the care plan dated 03/29/23 revealed Resident #37 required ADL assistance related to cardiovascular accident (stroke) with right hemiparesis, dementia, anxiety, depression, and arthritis. Interventions included assisting with meals and assisting with showers twice weekly. Review of the shower documentation for Resident #37 from 11/26/25 through 12/20/25 revealed a sponge bath was given on 11/26/25 and a bed bath was given on 12/20/25 (two of seven opportunities), with no showers documented. Observation on 12/18/25 at 9:35 A.M. revealed Resident #37 was sitting in a wheelchair near the 600 hall. Resident #37 had dry skin on her scalp and face. Further observation revealed Resident #37 had a large amount of an unknown substance under all of her fingernails. Interview on 12/18/25 at 9:56 A.M. with Certified Nursing Assistant (CNA) #203 revealed shower documentation was only completed in the electronic medical record (EMR) and included the type of shower or washing, how much staff assistance the resident required, and if the resident refused care. CNA #203 confirmed Resident #37 was to receive a shower twice weekly and the resident did not receive showers as scheduled. CNA #203 verified Resident #37 had a large amount of an unknown substance under her fingernails. Observation on 12/22/25 at 11:47 A.M. of the lunch meal service revealed two CNAs were in the main dining room. Further observation revealed Resident #37 was sitting at a table with one other resident and her lunch meal was sitting in front of her. Resident #37 was asking for her husband. Continuous observation revealed Resident #37 was not assisted with her lunch meal until 12:15 P.M., when CNA #213 began assisting her and another resident. Interview on 12/22/25 at 12:08 P.M. with CNA #213 revealed there were two CNAs in the dining room on most days to assist residents with eating. CNA #213 stated Resident #37 needed encouragement to eat and often required staff assistance with eating. CNA #213 verified Resident #37 was not assisted with eating in a timely manner. 3. Review of the medical record for Resident #84 revealed an admission date of 08/20/25. Diagnoses included spastic quadriplegic cerebral palsy, Barrett's Esophagus with dysplasia, and dysphagia. Review of the quarterly MDS assessment, dated 11/26/25, revealed Resident #84 had intact cognition. Review of the care plan dated 08/20/25 revealed Resident #84 had potential for alteration in nutrition and hydration status related to a mechanically altered diet and spastic quadriplegic cerebral palsy. Interventions included assisting with meals as needed. Further review of the care plan revealed Resident #84 required ADL assistance due to impaired mobility. Interventions included staff assistance with eating. Observation on 12/18/25 at 11:50 A.M. of the main dining room revealed seven residents who needed assistance or encouragement with eating and two CNAs were present to provide needed assistance. CNA #220 assisted</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, and staff interview, the facility failed to ensure physician orders were in place to monitor medication levels. This affected one (#100) of three residents reviewed for medication monitoring. The facility census was 99. Findings include: Review of the closed medical record for Resident #100 revealed an admission date of 04/01/25. Diagnoses included encounter for orthopedic aftercare, streptococcal arthritis of the left elbow, and osteomyelitis of the left humerus. Resident #100 discharged from the facility on 04/07/25. Review of the hospital discharge documents, dated 04/01/25, revealed Resident #100 was ordered intravenous (IV) vancomycin (antibiotic), 1,250 milligrams (mg) IV every 24 hours for 28 days and a vancomycin trough level (blood test to measure the level of vancomycin in the bloodstream to ensure the medication remains within a safe and effective range) weekly. A Peripherally Inserted Central Catheter (PICC) line (a type of long catheter that is inserted through a peripheral vein and used when IV treatment is required over a long period) was placed in the right upper arm. Resident #100 was to be discharged to a skilled nursing facility (SNF) for IV antibiotic therapy and rehabilitation therapy. A vancomycin trough level was drawn at the hospital on [DATE], prior to discharge. Review of the admission Minimum Data Set (MDS) assessment, dated 04/06/25, revealed Resident #100 had impaired cognition as evidence of a Brief Interview for Mental Status (BIMS) score of five. Resident #100 received antibiotic therapy. Review of the care plan dated 04/01/25 revealed Resident #100 received IV therapy via a PICC line for an infection in the left elbow. Interventions included inspecting the IV site at least every day, document and notify the physician of any signs and symptoms of infiltration, extravasation, phlebitis, or other abnormality at the IV insertion site, obtain laboratory (lab) tests as ordered, and vital signs as indicated and as needed. Review of the physician orders dated 04/02/25 revealed Resident #100 was to have a complete blood count (CBC) and basic metabolic panel (BMP) laboratory (lab) test every Wednesday. Staff were to assess the PICC line site every shift for signs and symptoms of complications. Additionally, Resident #100 was ordered vancomycin IV solution, 1,250 mg per 250 milliliters (ml) IV every 24 hours for osteomyelitis of the left elbow for 28 days. Further review of the physician orders revealed no orders for a vancomycin trough level to be completed. Review of a physician progress note dated 04/07/25 revealed Resident #100 was seen by Medical Doctor (MD) #207. New orders were received for Ativan (antianxiety medication that is also used to treat seizure activity) and a neurological consult. No orders were given to complete a vancomycin trough. Interview on 12/17/25 at 1:44 P.M. with the Director of Nursing (DON) verified Resident #100 did not have a physician order to complete a vancomycin trough (due to have been drawn on 04/07/25) to monitor the medication. This deficiency represents noncompliance investigated under Complaint Number 2679714.</p>		