

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 07/31/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>Based on record review, staf interview and policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level 1 was updated and resubmitted following a new diagnosis of a serious mental illness for one (Resident #13) of three residents reviewed for PASRR. The facility census was 94. Findings included: Review of Resident #13's Preadmission Screen/Resident Review (PAS/RR) Identification Screen, dated 01/06/20, revealed that Resident #13 had a diagnosis of dementia/Alzheimer's disease, and had diagnoses that included mood disorder and major depressive disorder. A review of the clinical record for Resident #13 revealed no evidence of any additional PASRR forms. Interview on 07/30/25 at 12:28 P.M., with the Social Services Director (SSD) stated when a new psychiatric diagnosis was added to a resident record, a new Level I PASRR would be completed. The SSD stated a new PASRR Level I should have been completed for Resident #13 when their schizoaffective disorder diagnosis was added. Interview on 07/31/25 at 11:07 A.M., with the Administrator and the Director of Nursing (DON), the Administrator stated it was her expectation that the PASRR was accurate and resubmitted when there was a significant change in the resident's condition or a new psychiatric diagnosis was added. The Administrator stated it was her expectation that a PASRR Level I would have been resubmitted for Resident #13 at the time the new psychiatric diagnosis was added. The DON stated she would defer to the Administrator for PASRR-related questions. Review of the policy titled, PASRR and Level of Care Policies for Ohio, dated 06/11/18, revealed, it is the policy of [Facility Name] to follow the State and Federal regulations related to completing the appropriate PASRR and Level of Care as needed on admission, following a 30 day stay, appropriate change in level of condition and as needed for payor change to Medicaid. The results of the PASRR or Level of Care will be maintained in the electronic medical record.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to post appropriate oxygen use signage for one (Resident #1) of three residents reviewed for respiratory care. The facility census was 94. Findings included: Review the admission record for Resident #1 on 06/06/25, with a diagnosis of pneumonia. Review of admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/13/25, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident received oxygen therapy while a resident at the facility. Review Resident #1's Care Plan, included a focus area initiated 06/08/25, that indicated the resident was at risk for impaired gas exchange due to sleep apnea, congestive heart failure, hypoxia, and exacerbation. Interventions directed staff to administer supplemental oxygen at the ordered flow rate by the practitioner. Review of the Physician Order, dated 06/23/25, specified Resident #1 was to receive oxygen at 2-4 liters per minute (lpm) via nasal cannula (NC) continuously for hypoxia related to pneumonia. Observation from the hallway of Resident #1's room on 07/28/25 at 11:01 A. M. revealed no Oxygen in Use sign on the resident's door. Observation of Resident #1's room on 07/30/25 at 9:24 A.M. revealed there was no Oxygen in Use sign on the resident's door. The resident was observed in bed sleeping and was receiving supplemental oxygen via nasal cannula. Interview on 07/30/2025 at 3:19 P. M., the Director of Nursing (DON) stated that an oxygen-in-use sign should have been on a resident's door whenever the resident was started on oxygen, and the resident's nurse or respiratory therapist should have put the sign on the door. Interview on 07/31/2025 at 10:28 A.M., with Administrator stated their expectation was that any resident on oxygen should have had a sign on their door. Review of policy titled, Oxygen Therapy, dated June 2024, indicated, 4.3.4 Fire hazard is increased in the presence of increased oxygen concentrations.</p>		