STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365646	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston of Ashland	20 Amberwood Pkwy Ashland, OH 44805

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, record review and interview, the facility failed to provide timely toileting assistance to Resident #1 who required staff assistance for activities of daily living (ADL). This affected one resident (#1) of three residents reviewed for assistance with ADLs. The facility census was 91. Findings include: Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included hemiplegia following a cerebral infarction, intracerebral hemorrhage in the brain stem, respiratory failure, dysarthria, obstructive hydrocephalus, depression, hepatitis, osteoarthritis, and history of transient ischemic attack. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition and was occasionally incontinent of bladder and always continent of bowel. Resident #1 required staff assistance for toileting and dressing. Review of Resident Council Minutes dated 08/14/24 revealed the residents at the meeting voiced concerns it took a while for the call lights to be answered. Observation on 09/09/24 at 10:30 A.M. revealed the call light monitor at the nurses' station indicated the call light for Resident #1's room had been on for 44 minutes. On 09/09/24 at 10:30 A.M. an interview with Licensed Practical Nurse (LPN) #296 verified the call light for Resident #1's room had been on for 44 minutes. On 09/09/24 at 10:45 A.M. an interview with Resident #1 revealed she had her call light on because she needed to go to the bathroom and wanted to get up and dressed for therapy. She stated she was supposed to have speech therapy at 9:00 A.M. so she turned her call light on at around 8:00 A.M. She stated the nursing assistant (did not know her name) came in and told her she would be right back but she never came back. She stated at 9:50 A.M. she put her call light on again and it had been on ever since. She stated she should just mess the bed but she does not want to do that. She stated sometime it takes two to three hours to get her call light answered in the morning. (continued on next page)

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/24 at 10:50 A.M. an interview with LPN #296 revealed the staff had not been into Resident #1 room yet but they were going into her room after they finished up in the room they were in at that time. On 09/09/24 at 10:58 A.M. the nursing assistant went into take care of Resident #1. On 09/10/24 at 8:30 A.M. an interview with Resident # 92 revealed it could take hours to get a call light answered when she needs help. She stated she has had to sit in her own stool for hours while waiting for assistance and sometimes the staff come in and tell her they will come back to help but they do not. On 09/10/24 at 3:45 P.M. an interview with Resident #106 revealed the call lights have gotten better since she said something in the Resident Council meeting but the problem was that the staff come into your room and tell you they would be back and they never come back then you have to turn the call light on again. On 09/10/24 at 2:55 P.M. an interview with the Director of Nursing (DON) revealed Resident #1 had complained to the staff about her call light being on for so long yesterday and the staff was educated and she requested to be moved to a more visible room and that move was done today. Review of the facility policy titled,Answering the Call Light, dated 02/23 revealed the purpose was to respond to the resident's requests and needs. This deficiency represents noncompliance investigated under Complaint Number OH00157222 and OH00157221.

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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 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** 35765 Based on record review and interview the facility failed to ensure daily weights and laboratory tests were obtained and/or reported as ordered for Resident #110. This affected one resident (#110) of four residents reviewed for quality of care. The facility census was 91. Finding included: 1. Review of the medical record revealed Resident #110 was admitted to the facility on [DATE]. Diagnoses included surgery to the digestive system, colostomy, malignant neoplasm of the sigmoid colon, congestive heart failure, chronic kidney disease, insomnia, dilated cardiomyopathy, and pacemaker. She was discharged to the hospital on 06/27/24. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 had intact cognition and had a surgical wound and ostomy. She needed set up assistance for eating and weighed 134 pounds (lbs). Review of the physician's orders revealed Resident#110 was order daily weights and to notify the provider of a weight gain of three pounds (lbs) in one day or five pounds in one week dated 06/05/24. Review of the daily weights for Resident #110 revealed no documentation of daily weights on 06/08/24, 06/10/24, 06/13/24, 06/14/24, 06/18/24, 06/19/24, 06/20/24 and 06/21/24. Review of the weights for Resident #110 revealed she weighed 133.6 lbs on 06/04/24, 133.8 lbs on 06/05/24 and 06/06/24, 139.0 lbs on 06/07/24, 140.2 lbs on 06/09/24, 127.0 lbs on 06/11/24, 123.0 lbs on 06/12/24, 123.7 lbs on 06/15/24, 123.7 lbs on 06/16/24, 123.6 lbs on 06/17/24, 124.6 lbs on 06/22/24, 128.0 lbs on 06/23/24, and 127.8 lbs on 06/24/24. On 09/12/24 at 10:33 A.M. an interview with the Director of Nursing (DON) confirmed the physician was not notified on 06/07/24 for Resident #110 having a 5.2-pound weight gain from 06/06/24 to 06/07/24 or on 06/24/24 for her 3.2-pound weight gain from 06/22/24 to 06/24/24. 2. Review of the medical record revealed Resident #110 was admitted to the facility on [DATE]. Diagnoses included surgery to the digestive system, colostomy, malignant neoplasm of the sigmoid colon, congestive heart failure, chronic kidney disease, insomnia, dilated cardiomyopathy, and pacemaker. She was discharged to the hospital on 06/27/24. Review of the admission MDS assessment dated [DATE] revealed Resident #110 had intact cognition and had a surgical wound and ostomy. Review of the physician's orders revealed Resident #110 had an order for a wound culture per the daughters request due to a change in drainage color dated 06/12/24. Review of the physician's orders revealed Resident #110 had an order for levofloxacin 500 milligrams once daily for seven dated for infection dated 06/19/24. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound culture of the lower abdomen wound with a collection dated of 06/12/24, received date of 06/14/24 and reported date of 06/18/24 revealed the culture was positive for the organism pseudomonas aeruginosa. Review of the Infection Control log revealed Resident #110 had a wound infection on 06/19/24 and was prescribed levofloxacin 500 milligrams. On 09/10/24 at 12:14 P.M. an interview with the DON revealed she was not with the company when the lab test was done for Resident #110 so she does not know why it was drawn on 06/12/24 but not sent to the lab until 06/14/24. She verified that was what the documentation stated. She stated the lab was short staffed just like everyone else and they try to get them to pick up every day but somedays they do not show up. This deficiency represents non-compliance investigated under Complaint Number OH00157221.

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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** 35765 Based on review of the medical record and interview with staff the facility failed to complete a thorough and timely post-fall assessment and notify the family of a fall for Resident #109. This affected one resident (Resident #109) of three reviewed for falls. The facility census was 91. Findings included: Review of the closed medical record revealed Resident #109 was admitted to the facility on [DATE]. Diagnoses included hemiplegia of the right side following a cerebral infarction, intracerebral hemorrhage, encephalopathy, pulmonary fibrosis, dysphagia, respiratory disorders, begin prostatic hyperplasia, kidney failure, hypertension, and atherosclerotic heart disease. He was discharged to the hospital on [DATE] where he later expired. Review of the physician's orders dated [DATE] revealed Resident #109 had orders for fall mats to both sides of the bed at bedtime and a low bed. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #109 had severely impaired cognition and was incontinent of bladder and bowel. He required partial/moderate assist with eating and was dependent for toileting and bathing. Review of the fall risk assessment dated [DATE] revealed Resident #109 was a high risk for falls. Review of the fall investigation report dated [DATE] revealed Resident #109 was found on [DATE] at 2:30 A. M. lying on the ground next to his bed with his head towards the head of the bed. A blanket was covering him and the call light was pinned to him. The resident was alert with no injuries noted at the time. Resident stated he rolled out of bed. The State tested Nursing Assistant (STNA) statement reports the resident stated his head hurt then denied anything hurting. Review of the undated, signed, handwritten witness statement from STNA #255 revealed on [DATE] (this was actually [DATE]) at around 2:00 A.M. she was assisting a resident to the bathroom when the nurse came into the room and stated Resident #109 was on the floor. When she walked into the room Resident #109 was on the floor parallel with the bed next to the heating unit, his head was under the red chair in the room and the nurse was standing beside him. Resident #109 was wrapped up in his blanket with his call light still attached to his shirt and his bed was in the low position. She went to get the Hoyer lift so they could get him up off the floor. They got him back into the bed and the nurse felt the back of his head for a goose egg and said there was not one. Resident #109 stated his head hurt then said nothing hurt. When she came back to work on [DATE] she thought Resident #109 did not seem to be doing well so she approached the nurse working that night and asked her what was going on with him because the other night he was talking to her. She asked her if there was any documentation of a fall and the nurse stated no. She told her what had happened on [DATE] (the date was actually [DATE]) and the nurse told her to report it. She stated there was no assessment or neurological assessment was done. (continued on next page)

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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	Review of the progress/nursing/skilled notes from [DATE] to [DATE] revealed no documentation of a neurological assessment being completed for Resident #109. Review of the physician's telehealth note dated [DATE] at 3:00 A.M. revealed Resident #109 was being seen due to complaints of pain. He had a diagnosis of chronic pain however he was unable to clearly state where and was not endorsing an exam however the nurse stated he did appear to be in pain. Review of the nursing note dated [DATE] at 12:19 P.M. revealed the family of Resident #109 was notified of a fall on [DATE]. The family was requesting the resident be sent to the hospital for a head scan. Review of the hospital records dated [DATE] revealed Resident #109 had a head scan during the hospitalization which confirmed a brain bleed that was aged/unchanged from prior imaging done in [DATE]. Resident #109 was placed on comfort care with hospice services and expired at the hospital. On [DATE] at 9:18 A.M. in interview with Family Member #400 revealed Resident #109 was admitted to the facility due to the brain bleed and she was concerned about him falling at the facility but he facility stated they would lower his bed and place mats on the floor which they did do. She stated they would be there all the time and it would take forever to get anyone to answer the call light, most times it was up to an hour. She stated on [DATE] her father was not acting right; he was very fidgety and kept holding his head saying oh my over and over. She stated she spent the night with her father on Friday, Saturday, and Sunday ([DATE], [DATE], and [DATE]). She stated on [DATE] her father was complaining of stomach pain and she explained to the nurse (patty) that this was how he was acting prior to the first brain bleed but she would not listen to her. She stated during the night she asked the nurse if her father could have something for a headache and the nurse stated to her is it his head or stomach and I told her to just give him some Tylenol. She stated they had a meeting on [DATE] with the Director of Nursing (DON) and another person because their father was declining so fast and wanted to know what to do and they were told that he had fallen on Thursday night ([DATE]) and it was not reported. They told them they wanted him sent to the hospital. She stated by then he was completely unresponsive. She stated the hospital did a cat scan which was negative but the physician at the emergency room (ER) stated they should have done a Magnetic Resonance Imaging (MRI) because that was the only way to really tell. She stated he was severely dehydrated and had a urinary tract infection. She stated her father passed away at the hospital. On [DATE] at 1:37 P.M. an interview with the DON revealed she was not employed at the facility with Resident #109 had fallen but she verified the documentation revealed he had fallen on [DATE] and it was not reported and there was no documentation of an assessment, vital signs or neurological assessment had been completed. She stated the nurse had been terminated due to the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:25 P.M. an interview with Registered Nurse # 401 revealed on the morning of [DATE] right before shift change at 6:00 A.M. she was at the desk charting and the call light for Resident #109 was on and the nursing assistant was in a room helping another resident so she went to answer it. She stated when she went into the room Resident #109 was hanging halfway out of the bed between the bed and the wall. She stated his bed was in the lowest position, the mats were on the floor, he was wrapped up in his blankets and the call light was clipped to the blanket by his head. She stated he said she had to go to the bathroom. She stated she went and got the nursing assistant and they got the Hoyer and put him back into bed. She stated she checked him over and did not see anything wrong him and she asked him if he was in pain and he stated no. She stated they changed his brief because he had been incontinent. She verified she had not charted on the incident or called the family because she did not believe it was a fall. On [DATE] at 2:46 P.M. an interview with STNA #255 revealed she worked 10:00 P.M. to 6:00 A.M. on [DATE] into [DATE]. She stated she walked passed Resident #109 room around 2:00 A.M. and he was lying on the floor mat on the side of the bed between the bed and the wall. She stated he had his blankets wrapped around him with his call light still attached to his blanket. She stated his call light was not on. She stated the nurse was sitting at the nurse's station so she asked her to come to the room because he was on the floor. She stated they got him up off the floor with the Hoyer, the nurse checked him out and there were no other issues with him the rest of the night. She stated she came back to work on [DATE] and she asked the nurse who was working that night if it was documented he had a fall and the nurse stated no and told her to write a statement and turn it so she did. This deficiency represents non-compliance investigated under Complaint Number OH00157236 and OH00157221.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on record review and interview the facility failed to ensure medication was obtained timely from the pharmacy for Resident #20. This affected one resident (#20) of four residents reviewed for pharmacy services. The facility census was 91. Finding included: Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, pulmonary fibrosis, chronic duodenal ulcer, hypertensive heart, kidney disease, atrial fibrillation, major depressive disorder, anxiety, chronic pain syndrome, glaucoma, and macular degeneration. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition. Review of the Medication Administration Record (MAR) revealed Resident #20 had not received her Entresto (heart failure medication) ,d+[DATE] milligram tablet twice a day from admission on [DATE] to [DATE]. Review of the progress notes on [DATE] at 11:08 A.M. revealed Resident #20 to have two plus non-pitting edema in both her legs. Review of the pharmacy delivery slip revealed six Entresto ,d+[DATE] milligram tablets were delivered on [DATE]. Review of the progress notes from [DATE] to [DATE] revealed no documentation the physician or nurse practitioner were notified the facility was unable to get Entresto for Resident #20. Review of the physician progress notes dated [DATE] and [DATE] revealed no documentation of Entresto not being available for Resident #20. On [DATE] at 10:45 A.M. an interview with Licensed Practical Nurse (LPN) #351 revealed she had called the pharmacy several times about the Entresto for Resident #20 and they kept telling her it would be delivered but it would never come in. She stated the last time she called they stated it was a billing issue. She stated they finally got it in a few days ago. She stated it was always something with the pharmacy. She verified Resident #20 had developed some edema in both her legs during that time. On [DATE] at 11:30 A.M. an interview with LPN #351 verified she never notified the physician the medication was not available from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:35 P.M. an interview with the Director of Nursing (DON) revealed the Entresto for Resident #20 was expensive and the pharmacy would not send it for Resident #20 because she did not have insurance at that time. She stated Medicare had her as deceased in the system. She stated they were attempting to get to straightened out. She stated she had the medication now. This deficiency represents noncompliance investigated under Complaint Number OH00157222.