| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365984 | A. Building<br>B. Wing | 09/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kingston of Miamisburg | 1120 South Dunaway Street<br>Miamisburg, OH 45342 |

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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, policy review, and record review, the facility failed to ensure a resident received an adequate supply of medications upon discharge to home. This affected one (#97) of three residents reviewed for discharge. The facility census was 95. Findings include: Review of Resident #97's medical record revealed Resident #97 admitted to the facility on [DATE]. Diagnoses included epilepsy. Resident #97 discharged from the facility on 06/28/25. The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 was cognitively intact. Resident #97's discharge was a planned discharge to home. Review of Resident #97's discharge care plan dated 06/18/25 revealed Resident #97 was admitted to the facility for a short-term stay utilizing rehabilitation therapy. Resident #97 had a goal to discharge home and needed assistance with planning post discharge care. Interventions included acknowledge family and resident concerns, identify and coordinate discharge planning needs, obtain needed durable medical equipment, identify and discuss barriers to discharge, social services to coordinate discharge planning with the resident, family and the interdisciplinary team, and social services to provide education on services and resources in the community. The progress note dated 06/25/25 at 12:14 P.M. revealed LSW #144 notified Resident #97 and her spouse that a Notice of Medicare Non-Coverage (NOMNC) with a last covered day of 06/27/25 had been issued by insurance. LSW #144 informed Resident #97 and her spouse that they had the right to appeal. Resident #97 and her spouse stated they were not sure if they wanted to appeal and stated they would think it over. LSW #144 explained that LSW #144 could make a referral to home health if they decided not to appeal or if the appeal was denied. Review of LSW #144's email to the home health provider dated 06/25/26 at 12:28 P.M. revealed Resident #97 was discharging home on [DATE] and LSW #144 would like to make a referral for physical therapy, occupational therapy, speech therapy, nursing and a home health aide. Review of Resident #97's care conference dated 06/27/25 revealed Resident #97 and the resident representative attended the care conference. Resident #97's discharge plan was reviewed. The progress note dated 06/28/25 at 10:15 A.M. revealed Resident #97's spouse came into the building that morning and was asking about Resident #97's discharge. The information was not relayed to Registered Nurse (RN) #501 about Resident #97's discharge on that date. Resident #97's spouse became very irate and said RN #501 could discharge her or he would just take her out of the facility anyway. RN #501 made a telephone call to the unit supervisor. Resident #97's spouse was adamant about leaving. The discharge was completed and the recapitulation of the stay, medication list, medications, and paperwork for discharge were sent home with the resident. The telephone order dated 06/28/25 revealed Resident #97 could discharge home on [DATE] with stated it was okay to send Resident #97's remaining medications and it was okay to send a two-week supply of medications. Resident #97 was to follow up with her primary care physician in one week. The telephone order was signed by NP #502 on 07/24/25. Review of Resident #97's discharge summary and recapitulation of stay assessment dated [DATE] revealed medication reconciliation was completed to prepare predischarge medications, a current medication list was provided to the resident and resident representative and medications and supplies were sent home with the resident. The assessment was signed by Resident #97. The progress note dated 06/30/25 revealed Resident #97 discharged home on [DATE]. Review of Resident #97's Medication Administration Record (MAR) from 06/01/25 to 06/28/25 revealed Resident #97 was prescribed Thiamine Mononitrate 100 milligrams (mg) give one tablet by mouth in the evening for a supplement; Prevacid 30 mg give one tablet by mouth one time a day for gastroesophageal reflux disease (GERD), Melatonin (a sleep aide) five mg give two tablets by mouth at bedtime, levetiracetam 750 mg give one tablet by mouth two times a day for seizures, Fluoxetine 20 mg give one tablet by mouth one time a day for an anti-depressant, Cholestyramine oral packet four grams (gm) give one packet by mouth two times a day for hyperlipidemia, atorvastatin calcium 40 mg give one tablet by mouth at bedtime for hyperlipidemia, and Aspirin 81 mg give one tablet by mouth one time a day for a preventative. The medical record from 06/18/25 to 06/28/25 revealed no documentation that any of Resident #97's prescriptions were sent to the pharmacy upon discharge from the facility on 06/28/25.Interview with RN #501 on 09/19/25 at 10:25 A.M. revealed RN #501 was not aware that Resident #97 was discharging on 06/28/25 until Resident #97's husband came to the facility and demanded that Resident #97 be discharged . RN #501 stated she contacted the supervisor, and the supervisor stated Resident #97 and her husband informed the facility that they were debating on appealing the insurance NOMNC and they still had not decided about the appeal at |