| 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 | 05/07/2026 |

| 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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and policy review, the facility failed to ensure food was stored and prepared in a safe and sanitary manner. This had the potential to affect all residents who receive food from the kitchen. The facility census was 85.Findings Included:1.Observation during the initial tour of the main kitchen on 05/04/26 at 8:20 A.M. with the Dietary Manager (DM) #74 revealed the walk-in refrigerator contained 80 slices of cake on dessert plates with no label or date, three large clear bags of waffles with no label or date, nine individual dessert cups with yogurt, two very large containers of pork loin with no label or date, sixty individual fruit cups with no label or date and 20 orange slices in dessert cakes with no label or date. The walk-in freezer had a large box of frozen hamburger patties that was open and exposed to air, no label or date. A large gallon bag of premade sandwich style eggs with no label or date. Observation of a large puddle of water under the sink. Observation of the heavily soiled dishwasher with dried food splatter running down the front and sides. Observation of food crumbs piled high on the top of the dishwasher. Observation of a heavily soiled with dirt and debris under the sink. Observed large strands of fuzzy material hanging from the ceiling tile over the dishwasher cycle. Interview with the DM #74 on 05/04/26 verified the identified findings in the walk-in refrigerator and freezer. DM #74 verified the fruit in the fruit cups were made on 05/03/26 and were not covered, labeled, or dated. DM #74 verified the two large pans with pork loin were made on 05/03/26 and did not have a label or date on them. DM #74 verified the large puddle of water under the sink, and she confirmed the sink had a leak causing the large puddle on the floor. DM #74 verified the heavily soiled dishwasher with dried food splatter running down the front and sides, and the food crumbs piled high on the top of the dishwasher. DM #74 verified the floor was heavily soiled under the sink with dirt and debris and there was large strands of fuzzy material hanging from the ceiling tile over the dishwasher cycle. 2. Observation 05/04/26 at 9:16 A.M. revealed kitchen number two had a heavily soiled window as you walked into the kitchenette area. Observation of the walls around the dishwasher were heavily soiled with dirt, debris and food splatter. Observed dried food splatter running down the sides of the dishwasher. Observation of brown items that appeared to be bugs in the light over the food preparation area. DM #74 observed large, blackened area behind the toaster on the white wall. Observed the large fan aimed at the food preparation aera was heavily soiled with fuzzy strips of debris hanging from it. Interview with DM #74 on 05/04/26 at 9:16 A.M. verified kitchen number two had a heavily soiled window as you walk into the kitchenette area. The walls around the dishwasher were heavily soiled with dirt, debris and food splatter. The dried food splatter running down the sides of the dining room. DM #74 revealed the brown items in the light over the dishwasher and food preparation were bugs in the light. The DM #74 verified a large, blackened area behind the toaster on the white wall. The large fan aimed at the food preparation aera was heavily soiled with fuzzy strips of debris hanging from it. Review of the facility policy titled Culinary Services, dated 07/10/25 revealed food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance. Further review of the policy confirmed food is covered, dated, and stored loosely to permit air circulation. |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interview, and policy review, the facility failed to ensure physician ordered monitoring was followed for the side effects of anticoagulant medication use. This affected one (Resident #11) out of six residents reviewed. The facility census was 85.Findings include:Review of the medical record for Resident #11 revealed an admission date of 01/01/25. Diagnoses included Alzheimer's disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type Two, vascular dementia, myocardial infarction and depression. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had a Brief Interview Mental Status (BIMS) score of 13 indicating intact cognition. The resident required set up with eating, maximum assistance with transfers, bed mobility and was dependent upon staff with toileting hygiene, A care plan for risk for injury related to anticoagulant use initiated 01/02/25 with individualized interventions which included assess for signs and symptoms of active bleeding (hemoptysis, epistaxis, hematuria, coffee ground emesis/stool, bright red blood in stool, petechiae, hematoma, etcetera) and notify physician if observed.Observation and interview on 05/04/26 at 10:40 A.M. revealed Resident #11 was seated in a wheelchair, dressed in a long-sleeved shirt and pants. A bruise was visible on his right hand. Upon questioning, Resident #11 stated the bruise was caused by hitting his hand on the underside of his bedside table.Review of the electronic charting revealed no skin assessment documenting a bruise to Resident #11's right hand.Review of the physician orders revealed an order for Eliquis (anticoagulant medication) 2.5 milligrams (mg) daily with a start date of 01/01/25. An order for anticoagulant bleeding precaution: Assess for signs and symptoms of active bleeding (hemoptysis, epistaxis, hematuria, coffee ground emesis/stool, bright red blood in stool, petechiae, hematoma, etcetera ). Monitor for bruising/bleeding and notify physician if observed.Review of the May Treatment Administration Record revealed the anticoagulant assessment, including the monitoring for bruising/ bleeding and notification of physician had been documented as completed on each shift.Interview on 05/07/26 at 10:00 A.M., with the Assistant Director of Nursing (ADON) #111 revealed she was responsible for wound care at the facility. She stated it would be the expectation of the facility for a nurse to document a skin assessment and update the physician if a bruise was observed on a resident receiving anticoagulant medication. ADON #111 reviewed the electronic charting of Resident #11 and verified no documentation of a skin assessment or physician notification of a current bruise for Resident #11. The ADON acknowledged documentation for the anticoagulant assessment, including the monitoring for bruising/bleeding and notification of physician had been documented as completed on each shift.Observation on 05/07/26 at 10:58 A.M. with ADON #111 of Resident #11 revealed ADON #111 assessed the right hand of Resident #111. ADON #111 traced the outline of the bruise of Resident #11's hand with her index finger as she asked him how he received it. Resident #11 responded he hit his hand on the bedside table. ADON #111 asked when it occurred and Resident #11 stated it had happened a few days ago.A follow-up interview with the ADON #111 directly following her assessment verified a skin assessment and physician notification should have been completed.Review of the facility policy titled Wound and Skin Management Guidelines, undated documented bruise goal was to protect and monitor. If a bruise was identified in house the investigation protocol should be initiated, complete an initial assessment of each bruise, obtain an order to monitor the bruise every shift until resolved and document any abnormalities in the medical record. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to ensure medication was stored in a safe manner. This affected one (Resident #07) out of three Residents (#07, #14, #100) reviewed for medication storage. The facility census was 85.Findings Included:Medical record review revealed Resident #07 was admitted to the facility on [DATE]. Diagnoses included polyarthritis, scoliosis, hyperglyceridemia, essential primary hypertension, mixed hyperlipidemia, dysphagia, and constipation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #07 had impaired cognition. Further review of the MDS assessment, revealed Resident #07 was dependent on staff for medication administration, toilet use, bathing, lower body dressing, putting on shoes, and personal hygiene. Observation on 05/04/26 at 10:35 A.M. revealed Resident #07 was seated in her wheelchair with her overbed table over her wheelchair. To the left of Resident #07 on the dresser was a medication cup with ten pills in the cup and the cup had a plastic strip with Resident #14's name on it. Interview with Licensed Practical Nurse (LPN) #96 on 05/04/26 at 10:36 A.M., verified a medication cup with ten medications were on Resident #07's dresser with a plastic slip that had Resident #14's name on it. LPN #96 verified the slip on the cup of medications documented it was for Resident #14 for the A.M. medications for 05/03/26. The following medications were identified in the pill cup left on Resident #07's dresser for Resident #14; aspirin (antiplatelet) 81 milligram (mg), Thera M (multivitamin) 1 tablet, ferrous gluconate (iron deficiency) 324 mg, spironolactone (edema) 25 mg, losartan potassium (high blood pressure medication) 25 mg, zinc sulfate (supplement) 220mg, amlodipine besylate (high blood pressure medication) 5 mg, metformin (diabetic medication) 500 mg, and cyanocobalamin (vitamin B-12 deficiency) 500 microgram (mcg), and cholecalciferol (vitamin D deficiency) 1000 unit. Interview on 05/04/26 at 12:11 P.M., with the Director of Nursing (DON) verified Resident #14's morning medication from Sunday morning 05/03/26 at 8:00 A.M. were left on the dresser of Resident #07's dresser with a plastic strip with Resident #14's medication. The DON verified both Resident #07 and Resident #14 required medication administration from the staff. The DON said she spoke with LPN #109 who was the nurse for Resident #07 and Resident #14 on 05/03/26 for the morning shift. The DON verified LPN #109 revealed she pulled Resident #14's pills to administer them. LPN #109 stopped to answer the call light for Resident #07 and sat Resident #14's pills on resident #07's dresser and forgot where she put them. LPN #109 revealed she returned to the medication cart and thought she may have thrown Resident #14's pills out so LPN #109 pulled more medication for Resident #14 and administered the medication. Interview on 05/05/26 at 1:15 P.M., with LPN #109 verified she was the nurse for Resident #07 on 05/03/26 in the A.M. LPN #109 revealed she pulled the medications for Resident #14 and placed them in a medication cup. LPN #109 revealed she walked into Resident #07's room to answer her bathroom call light and sat Resident #14's medication on the dresser of Resident #07. LPN #109 revealed she returned to the medication cart and thought she had thrown out the medication for Resident #14 so LPN #109 repulled the medications for Sunday morning medication administration for Resident #14 from the medication cart. 2. Medical record review for Resident #14 revealed she admitted to the facility on [DATE]. Diagnoses included diabetes mellitus (DM), peripheral vascular disease, hypothyroidism, osteoporosis, and depression. Review of the MDS assessment dated [DATE] for Resident #14 revealed she was cognitively intact. Resident #14 was dependent on staff for medication administration, toilet use, showers, lower body dressing, putting on shoes, and personal hygiene. Review of the Medication Summary for Resident #14 verified she required the following A.M. medications; aspirin 81 mg, Thera M 1 tablet, ferrous gluconate 324 mg, spironolactone 25 mg, losartan potassium 25 mg, zinc sulfate 220mg, amlodipine besylate 5 mg, metformin 500 mg, and cyanocobalamin (vitamin B-12 deficiency) 500 microgram (mcg), and cholecalciferol 1000 unit. |