STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366305	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Care Center of Sylvania	4121 King Road Sylvania, OH 43560

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, staff interview, review of maintenance work orders, review of call light logs and review of policy, the facility failed to maintain a functional call light system. This affected six (#37, #38, #44, #59, #78, and #108) with the potential to affect all 105 residents in a facility. The total facility census was 105. Findings include: Observation on 10/24/24 at 4:20 A.M., revealed the green light above Resident #38's room was illuminated. Interview on 10/24/24 at 4:20 A.M., with Licensed Practical Nurse (LPN) #207 revealed the green light above each resident room is intended to illuminate when a member of therapy staff is in the room with the resident. Observation on 10/24/24 at 4:22 A.M., revealed Resident #38 was asleep in her room with no therapy staff present. Interview on 10/24/24 at 4:23 A.M., with LPN #207 verified the light was green above the door but no staff were in the room. Observation on 10/24/24 at 5:27 A.M., revealed the green light above Resident #38's room continued to be illuminated. Interview on 10/24/24 at 5:28 A.M., with LPN #207 verified the green light has remained on. Observation on 10/24/24 at 4:35 A.M., revealed Resident #37, #44, #59, #78, and #108's call light to be alarming. Interview on 10/24/24 at 4:49 A.M., with LPN #303 revealed the call lights utilize are called Versus and in order for the call light to be shut off, a staff member must enter the room wearing a badge and there is no other way to shut the call light off. LPN #303 revealed all nursing staff do not have a Versus badge, as a contracted agency staff member took it with them. LPN #303 revealed that staff members who respond to a call light and do not have a Versus badge to use will use the Versus badge from another staff member. (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/24/24 at 5:02 A.M., with LPN #303 verified the call light for Residents #37, #44, #59, and #108 are still alarming despite staff members entering and exiting the rooms. Interview on 10/24/24 at 5:07 A.M., with the Director of Nursing (DON) revealed a staff member must wear a Versus badge when responding to a call light, but the facility is short on badges due to agency staff not returning them at the conclusion of their shift. Observation on 10/24/24 at 5:12 A.M., revealed State tested Nursing Assistant (STNA) #436 enter the room of Resident #37 while the call light was alarming, while wearing a Versus badge, and the call light ceased to alarm. When STNA #436 exited Resident #37's room, the call light instantly turned back on. This occurred multiple times as STNA #436 entered and exited Resident #37's room. Interview on 10/24/24 at 5:15 A.M., with STNA #436 and LPN #330 revealed the call light in Resident #37's room will malfunction if pulled too hard and it gets pulled out from the wall slightly. The wall unit for Resident #37's call light has to be adjusted back to the appropriate position on the wall to function properly. Review of maintenance work orders for the previous month revealed eight documented instances of malfunctioning call lights in the facility. A work order was placed on 10/07/24 when the call light in 115-A was not working and this was resolved on 10/09/24. A work order was placed on 10/08/24 when room [ROOM NUMBER] was having call light issues and this was resolved on 10/10/24. A work order was placed on 10/09/24 for room [ROOM NUMBER]-A that the call light was beeping and flashing. A work order was placed on 10/13/24 for room [ROOM NUMBER]-B because the call light was not working, and this was resolved on 10/14/24. A work order was placed on 10/14/24 for room [ROOM NUMBER] so that the call light was not working, and this was resolved on 10/14/24. A work order was placed on 10/16/24 for room [ROOM NUMBER] that the call light in the wall was beeping and this was resolved on 10/16/24. A work order was placed on 10/81/24 for room [ROOM NUMBER] and the call light stopped working and this was resolved on 10/21/24. A work order was placed on 10/22/24 for room [ROOM NUMBER] that the call light was stuck, and this was resolved on 10/22/24. Review of the facility provided call light log for 10/17/24-10/23/24, showed a location (room number), number of call lights for the day (12:00 A.M. - 11:59 P.M.), and average response time. On 10/17/24, the call light for unoccupied room [ROOM NUMBER] was on for 3 hours and one minute. On 10/18/24, the call light for room [ROOM NUMBER], was on for 14 hours and 31 minutes. room [ROOM NUMBER] was unoccupied on these dates. There is a work order documented as placed on 10/22/24 for room [ROOM NUMBER] that was documented as resolved on the same day. Interview on 10/24/24 at 7:05 A.M., with the Administrator revealed the facility staff are to let the charge nurse know when the Versus badge is not functioning appropriately or it needs new badges. The Administrator revealed she is unsure of the maintenance schedule for the facility call light system but will discuss this with the facility Director of Maintenance. The Administrator revealed that if the call light system is not functioning appropriately, the facility provides the affected residents with bells for them to manually ring. Interviews with the Administrator revealed the facility has 189 badges. The Administrator stated the facility is implementing a process where the Versus badges will have a Wander Guard attached to them so the agency staff will not be able to remove them from the facility. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 10/24/24 at 7:20 A.M., with the DON revealed there are no residents who currently reside in the facility who are physically or cognitively unable to utilize the call light system either with the traditional call light or a modified call light pad. Interview on 10/24/24 at 9:00 A.M., with the Regional Manager revealed the facility does not maintain a call light log, but the call lights are monitored by Versus System in Traverse City, Michigan. The Regional Manager revealed the Director of Maintenance was unable to be contacted regarding the call light system as his position was terminated on 10/23/24. Review of the policy titled, Answering the Call Light, dated February 2023, revealed staff are to report all defective call lights to the nurse supervisor promptly.