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	10/08/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, review of facility submitted Self-Reported Incidents (SRI), review of personnel records, and review of the facility policy, the facility failed to ensure residents were free from staff-to-resident abuse. This affected one (#108) of three residents reviewed for abuse. The facility census was 117.Findings include:Review of the medical record revealed Resident #108 was admitted on [DATE]. Diagnoses included unspecified dementia moderate with other behavioral disturbances, chronic kidney disease stage two, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and dysphagia oropharyngeal phase.Review of the Minimum Data Set (MDS) assessment, dated 08/19/25, revealed the resident was severely cognitively impaired and required substantial assistance with chair to bed transfers. Review of nursing progress note, dated 09/23/25 at 7:15 A.M. revealed a bruise was noted under Resident #108's left eye. Another nurse asked what happened to her eye and the resident stated someone hit me in the eye. The bruise was noted to be 0.5 centimeters (cm) x 1.5 cm red and blue. The resident reported a lady hit her in the eye last night but could not provide any additional details. Review of nursing progress note, dated 09/23/25 at 7:18 A.M. revealed a head-to-toe assessment was completed and noted a bruise to the left wrist measuring 4 cm x 3 cm. Review of physician progress noted, dated 09/23/25, revealed Resident #108 was clinically stable and found to have two areas of ecchymosis this morning with one located under her left eye and another on her left wrist. No indication of fractures and the resident denies pain. Review of Weekly Skin Observation, dated 09/23/25, revealed new skin impairment was identified on Resident #108's left wrist measuring 4 cm x 3 cm described as red and blue and a bruise under the left eye measuring 0.5 cm x 1.5 cm. Review of Non-Pressure Injury Review, dated 09/23/25, revealed a wound was located below the left eye measuring 0. 5 cm x 1.5 cm and left wrist out aspect 4 cm x 3 cm. Review of physician orders, dated 09/23/25, revealed new orders to monitor the bruise under the left eye every shift until healed and monitor the bruise to the left wrist every shift until healed. Interview on 10/09/25 at 11:20 A.M. with Licensed Practical Nurse (LPN) #276 verified she had observed Resident #108 on 09/23/25 and noted a bruise under her left eye that had not been there the day before. Interview on 10/09/25 at 11:27 A.M. with LPN #277 verified working with Resident #108 the following day and completed the skin assessments. LPN #277 stated Resident #108 appeared to be at baseline. Interview on 10/09/25 at 2:19 P.M. with Certified Nursing Assistant (CNA) #275 verified she had worked on 09/22/25 from 2:00 P.M. to 10:00 P.M. and provided care to Resident #108 with CNA #300. CNA #275 stated she is new to healthcare and it was her third day in orientation. CNA #275 stated while providing care to Resident #108, CNA #300 was being aggressive. It was reported CNA #300 was attempting to assist the resident in transferring to bed and the resident was grabbing CNA #300's wrists. In return, CNA #300 grabbed onto Resident #108's wrists. CNA #275 stated CNA #300 threw Resident #108 on the bed and when doing so the bed bounced a little. CNA #275 assisted by taking Resident #108's feet and gently placed them on the bed. CNA #275 stated she does not know when the bruising could have occurred especially to the face as she never saw any contact with the resident's face. Review of Self-Reported Incident (SRI) #265552, dated 09/23/25, revealed an allegation of physical abuse of Resident #108 with the perpetrator identified as CNA #300. Resident #108 was found to have a bruise under her left eye and a bruise on her wrist. Once identified, Resident #108 received a head-to-toe assessment. CNA #300 was identified as the caretaker who provided care to Resident #108 and CNA #300 was suspended pending investigation. Resident #108 indicated she was hit in the eye but could not recall who did it. A CNA who was working with CNA #300 stated she thought the aide was being aggressive in that she had grabbed the resident's arms and the resident said ow. Resident #108's roommate indicated the nurse was rough with the resident. Neither witness observed Resident #108 being struck in the face or indicated that it appeared the aide intended to hurt Resident #108. It was reported the resident was combative during care and the resident was agitated and aggressive when she was put to bed. The allegation was unsubstantiated due to inconclusive evidence. As a result of the investigation, the facility dismissed CNA #300 from employment. The police were notified and the family opted not to press charges. Review of witness statement, dated 09/23/25, with CNA #275 verified she had assisted CNA #300 get Resident #108 to bed. CNA #275 stated CNA #300 was aggressive stating she picked the resident up and threw her into bed. CNA #275 lifted the

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, review of a facility submitted Self-Reported Incident (SRI), and review of facility policy, the facility failed to ensure staff timely reported allegations of abuse. This affected one (#108) of three residents reviewed for abuse. The facility census was 117.Findings include:Review of the medical record revealed Resident #108 was admitted on [DATE]. Diagnoses included unspecified dementia moderate with other behavioral disturbances, chronic kidney disease stage two, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and dysphagia oropharyngeal phase.Review of the Minimum Data Set (MDS) assessment, dated 08/19/25, revealed the resident was severely cognitively impaired and required substantial assistance with chair to bed transfers. Review of a nursing progress note dated 09/23/25 at 7:15 A.M. revealed a bruise was noted under Resident #108's left eye. Another nurse asked what happened to her eye and the resident stated, someone hit me in the eye. The bruise was noted to be 0.5 centimeters (cm) x 1.5 cm red and blue. The resident reported a lady hit her in the eye last night but could not provide any additional details. Review of Non-Pressure Injury Review, dated 09/23/25, revealed a wound was located below the left eye measuring 0.5 cm x 1.5 cm and left wrist out aspect 4 cm x 3 cm. Review of the facility submitted SRI, dated 09/23/25, revealed an allegation of physical abuse of Resident #108 with the perpetrator identified as CNA #300. Resident #108 was found to have a bruise under her left eye and a bruise on her wrist. Once identified, Resident #108 received a head-to-toe assessment. CNA #300 was identified as the caretaker who provided care to Resident #108 and CNA #300 was suspended pending investigation. Resident #108 indicated she was hit in the eye but could not recall who did it. A CNA who was working with CNA #300 stated she thought the aide was being aggressive in that she had grabbed the resident's arms and the resident said ow. Resident #108's roommate indicated the nurse was rough with the resident. Neither witness observed Resident #108 being struck in the face or indicated that it appeared the aide intended to hurt Resident #108. It was reported the resident was combative during care and the resident was agitated and aggressive when she was put to bed. The allegation was unsubstantiated due to inconclusive evidence. As a result of the investigation, the facility dismissed CNA #300 from employment. The police were notified, and the family opted not to press charges. Interview on 10/09/25 at 2:19 P.M. with Certified Nursing Assistant (CNA) #275 verified she had worked on 09/22/25 from 2:00 P.M. to 10:00 P.M. and provided care to Resident #108 with CNA #300. CNA #275 stated she was new to healthcare and it was her third day in orientation. CNA #275 stated while providing care to Resident #108, CNA #300 was being aggressive. CNA #300 was attempting to assist the resident in transferring to bed, and the resident was grabbing CNA #300's wrists. In return, CNA #300 grabbed onto Resident #108's wrists. CNA #275 stated CNA #300 threw Resident #108 on the bed and when doing so the bed bounced a little. CNA #275 assisted by taking Resident #108's feet and gently placed them on the bed. CNA #275 stated she did not know when the bruising could have occurred, especially to the face, as she never saw any contact with the resident's face. CNA #275 verified not reporting the incident immediately, stating she was new and did not know who to tell. Review of policy, Abuse and Neglect- Staff Treatment of Residents, dated 03/03/20, verified residents have the right to be free from abuse, neglect, and exploitation. Every employee has a responsibility to report immediately any and all known instances of abuse, neglect or misappropriation of property, which may be self-inflicted or caused by employees, other residents, or visitors. The deficiency was corrected on 10/06/25 when the facility implemented the following corrective actions: On 09/23/25, LPN #277 assessed Resident #108 for injuries and psychosocial wellbeing. On 09/23/25, the DON or designee initiated re-educated for all facility staff on the abuse policy and reporting of allegations of abuse timely. Evidence was received to verify education was completed on 09/30/25. On 09/23/25, CNA #300 was suspended pending investigation and terminated on 09/24/25. On 09/23/25, the DON provided CNA #275 one-on-one education on timely reporting of potential abuse allegations or concerns. On 09/23/25, the DON or designee interviewed all interviewable residents to ensure they felt safe and there were no further concerns of abuse. On 09/23/25, the DON or designee completed head-to-toe assessments on all residents who were not interviewable. No concerns were identified. On 09/25/25, an AD-HOC Quality Assurance and Performance Improvement (QAPI) committee meeting was held to review the incident and the corrective action implemented. Beginning