

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/12/2026
NAME OF PROVIDER OR SUPPLIER  Kingston Care Center of Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interview, review of the medical record, and review of the menu spreadsheet, the facility failed to ensure residents on a pureed diet received adequate protein portions. This affected all five residents (#5, #21, #72, #80, and #124) on a pureed diet. Additionally, the facility failed to ensure residents on a pureed diet received all menu items on their meal tray. This affected one (#80) of one resident observed for menu items. Further, the facility failed to ensure residents received double portions as ordered. This affected one (#77) of three residents reviewed for nutrition. The facility census was 122. Findings include: 1. Observations on 01/07/26 beginning at 11:37 A.M. revealed [NAME] #729 and [NAME] #727 plating meals for the noon meal, including trays for residents on a pureed diet.</p> <p>Interview and observation on 01/07/26 at 11:59 A.M. with [NAME] #727 confirmed a blue handled serving scoop was used to plate pureed beef brisket.</p> <p>Follow-up observation on 01/07/26 at 12:45 P.M. revealed the kitchen had completed serving noon meals, and all serving utensils remained in the serving containers, including the blue scoop in the pureed beef brisket.</p> <p>Interview on 01/07/26 at 12:45 P.M. with [NAME] #731, and concurrent review of the menu spreadsheet for the noon meal served 01/07/26, revealed residents on a pureed diet should receive a #6 scoop size portion of pureed beef brisket. [NAME] #731 stated the blue scoop used to serve pureed beef brisket was a two-ounce portion. [NAME] #731 further stated a #6 scoop provided a five-and 1/3 ounce portion of protein. [NAME] #731 confirmed residents on a pureed diet received less than half of the serving size identified on the menu spreadsheet.</p> <p>2. Record review for Resident #80 revealed an admission date of 11/27/25 with diagnoses of dysphagia and dementia. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 12/04/25, revealed Resident #80 had impaired cognition and was able to eat with setup or clean-up assistance. Review of the physician order initiated 11/30/25, and revised 12/29/25, revealed Resident #80 received a regular diet with blenderized (pureed) texture and thin liquids.</p> <p>Observation on 01/07/26 at 11:55 A.M. revealed [NAME] #729 plating a pureed meal tray. No pureed bread was observed to be plated with the meal.</p> <p>Interview on 01/07/26 at 12:00 P.M. with [NAME] #729 revealed she served the pureed bread under the protein portion on the plate.</p> <p>Observation on 01/07/26 at 12:13 P.M. of Resident #80's meal plate, and concurrent interview with</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 366305
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interim Dietary Manager #708, confirmed no evidence of a bread serving was under the pureed meat on Resident #80's plate.</p> <p>Review of the menu spreadsheet for the noon meal on 01/07/26 revealed residents on a pureed diet should receive a pureed bread serving.</p> <p>3. Review of Resident #77's medical record revealed an admission date of 11/07/26. Diagnoses included diabetes mellitus type two, cardiomegaly, and morbid obesity.</p> <p>Review of Resident #77's 5-day admission MDS dated [DATE] revealed her cognition was intact.</p> <p>Review of Resident #77's most recent care plan revealed having choices were important to her. The resident was at risk for impaired skin integrity related to diabetes mellitus, morbid obesity, and impaired circulation. Interventions included to give treatments as ordered.</p> <p>Review of Resident #77's medical order revealed a physician's order dated 11/10/25 for no concentrated sweets diet, regular texture, and thin consistency related to type II diabetes mellitus with diabetic polyneuropathy.</p> <p>Review of Resident #77's dietary note dated 12/15/25 revealed the resident had a high body mass index (BMI.) Previously the resident was ordered a liquid protein drink, but did not like the flavor. A new recommendation was made to begin double protein meals.</p> <p>Interview with Resident #77 on 01/07/26 at 10:57 A.M. revealed she was to receive double protein meals, but failed to receive the proper diet.</p> <p>Observation of Resident #77's meal tray on 01/07/26 at 1:08 P.M. revealed the resident 's meal contained two sweet potatoes, two dinner rolls, approximately one cup of shredded meat, mixed vegetables, cranberry juice, a cookie, and small container of brown sugar. Review of the portion size spreadsheet dated 01/07/26 revealed the single portion serving of meat was eight ounces, so Resident #77 should have received 16 ounces of meat.</p> <p>Interview with Dietary Manager #708 on 01/08/26 at 7:50 A.M. revealed Resident #77 was to receive double protein at lunch and dinner. Review of the resident's meal ticket revealed it read double protein, Dietary Manger #708 verified the resident had been receiving double portions instead of double protein.</p> <p>Interview with Dietician #686 on 01/12/26 at 1:24 P.M. revealed she ordered double protein meals for lunches and dinners for Resident #77 on 12/15/25. Dietician #686 verified the dietary manager placed the order in the dietary computer program and the resident's meal tickets were printed properly as double protein. When explained to the dietician what the resident had received for her meal, she stated the staff are providing double portions instead of double protein. In addition, she verified that the order in the medical record read regular texture, thin consistency and no concentrated sweets and failed to be updated as double protein.</p> <p>Review of the facility policy titled Diet Orders, dated August 2018 revealed diets will be offered as ordered by the physician. The dietetics professional will be notified of any special diets not listed on the menu, so that they can be written.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on resident interview, review of a test tray, and staff interview, the facility failed to ensure resident meals were palatable and served at an appropriate temperature. This had the potential to affect all 122 residents in the facility. Findings include: Interview on 01/05/26 at 9:53 A.M. with Resident #112 revealed the vegetables were overcooked and the portions seemed to be getting smaller.</p> <p>Interview on 01/05/26 at 10:22 A.M. with Resident #36 revealed the food was visually unappealing, was not seasoned, and was cold.</p> <p>Interview on 01/05/26 at 10:55 A.M. with Resident #77 revealed the food was cold and bland.</p> <p>Interview on 01/05/26 at 12:00 P.M. with Resident #20 revealed the food was always cold and did not taste good.</p> <p>Interview on 01/05/26 at 2:48 P.M. with Resident #83 revealed she did not like the food and the food was often cold.</p> <p>Interview on 01/06/26 at 9:14 A.M. with Resident #130 revealed Resident #130 often asked for meal substitutes because the main meal was always cold and unseasoned.</p> <p>Interview on 01/07/06 at approximately 9:30 A.M. with [NAME] #727 revealed the beef brisket needed to be cooked to at least 165 degrees Fahrenheit (F) before serving.</p> <p>Observation on 01/07/06 at 11:02 A.M. revealed [NAME] #729 taking the temperature of beef brisket upon removal from the steamer oven. Continued observation and concurrent interview revealed the meat temperature was 51 degrees F. [NAME] #729 stated the meat would need to reach appropriate temperature before service began at 11:30 A.M.</p> <p>Interview on 01/07/06 at 11:37 A.M. with [NAME] #729 stated she already began serving meal trays. [NAME] #729 stated the beef brisket reached a temperature of 202 degrees F when she removed it from the oven.</p> <p>Observation on 01/07/06 at 11:40 A.M. revealed Interim Dietary Manager (IDM) #708 checking the temperature of the beef brisket. Continued observation and concurrent interview with IDM #708 revealed the beef brisket temperature was 160 degrees F.</p> <p>Interview on 01/07/06 at 11:40 A.M. with [NAME] #729 regarding the discrepancy of the beef brisket temperature from 202 degrees F to 160 degrees F revealed [NAME] #729 stated the gravy she mixed into the beef brisket must have cooled down the meat temperature.</p> <p>Observations on 01/07/06 beginning at 11:59 A.M. revealed [NAME] #729 plated a test tray. The test tray left the kitchen at 12:02 P.M. and had to be carried individually by Dietary Aide #721 as staff did not load it on the cart. The meal tray arrived on the floor at 12:04 P.M. but was on a tray too large for the cart. The tray was set on a counter in the hall. At 12:05 P.M. Dietary Aide #721 brought a tray from the kitchen and put the test tray on the new tray and loaded it into the cart. IDM #708 joined the surveyor on the floor at 12:06 P.M. The first meal tray was passed by staff at 12:08 P.M. The final meal tray was passed by staff at 12:23 P.M. At 12:23 P.M. the test tray was removed from the cart and taken the dining room.</p> <p>(continued on next page)</p>		

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