

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 Health 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)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 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. 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. Interview on 01/05/26 at 10:55 A.M. with Resident #77 revealed the food was cold and bland. Interview on 01/05/26 at 12:00 P.M. with Resident #20 revealed the food was always cold and did not taste good. 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. 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. 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. 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. 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. 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. 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. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Review of the test tray on 01/07/06 beginning at 12:23 P.M. revealed IDM #708 used a thermometer to determine the beef brisket temperature was 125 degrees F. Concurrent sampling of the test tray by the Surveyor and IDM #708 revealed the beef brisket was warm, but not hot, and was bland and not very flavorful. Further review revealed the mixed vegetables were cool and very bland and seemed to only be seasoned with black pepper. No concern was identified with the baked sweet potato, which was palatably warm, a creamy texture, and flavorful without any additional seasonings. Interview on 01/07/06 at 12:35 P.M. with Resident #77 stated she had not begun to eat her meal as staff was providing personal care assistance, but stated the lid and plate felt warm, and further stated that's a first. Follow-up interview on 01/07/26 at approximately 12:45 P.M. with Resident #77 revealed concerns regarding the taste and temperature of her lunch. Resident #77 stated that the taste of today's lunch food was inferior and less than lukewarm. The resident also stated that six to seven of her meals between lunch and supper per week consist of chicken noodle soup as an alternative because she was not happy with what was typically served. Interview on 01/07/06 at approximately 12:50 P.M. with Resident #20 revealed she had not yet received her meal tray and was actively working with therapy. Interview on 01/07/06 at 2:26 P.M. with Resident #20 revealed she attempted to eat the beef brisket but found it too chewy and without flavor. Resident #20 requested a substitute and received a hamburger instead of the beef brisket. Resident #20 stated she was able to make the mixed vegetables palatable by adding seasonings and butter.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, review of the legionella weekly fixture exercise logs for the year of 2025, staff interview, and policy review, the facility failed to ensure documentation for legionella prevention was accurate. This had the potential to affect all residents. Furthermore, the facility failed to ensure medications were accurately transcribed and the medical record was accurate regarding the receipt of medications for Resident #20. This affected one resident (#20) of four residents reviewed for accurate medical records. The facility census was 122. Findings include: 1. Review of the Legionella weekly fixture exercise log for the year of 2025 revealed the documents for July, August, and September had been copied and used again for the months of October, November, and December. Interview on 01/07/26 at 12:52 A.M. with Regional Nurse/Registered Nurse #800 verified the Legionella documents were photocopied. Interview on 01/07/26 at 2:50 P.M. with Maintenance Assistant (MA) #689 verified he had made copies of the forms because he does not like to write and it would take more time. The facility did not have a policy regarding accurate documentation. 2. Review of Resident #20's medical record revealed an admission date of 12/22/25. Diagnoses included acute kidney failure, cellulitis of the right lower limb, hypertensive heart disease, congestive heart failure, metabolic syndrome, chronic obstructive pulmonary disease, type two diabetes mellitus, and gastroesophageal reflux disease. Review of Resident #20's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #20 had intact cognition. Review of Resident #20's physician orders revealed an order on 12/22/25 for Cozaar oral tablet 25 milligram (mg) with instructions to give one tablet by mouth one time a day for hypertension. Review of Resident #20's Medication Administration Record (MAR) for the months of December 2025 and January 2026 revealed an order for Cozaar oral tablet 25 mg with instructions to give one mg by mouth one time a day for hypertension. Interview on 01/06/26 at 11:43 A.M. with Licensed Practical Nurse (LPN) #684 verified there was a discrepancy between the physician's orders and the MAR for the Cozaar ordered for Resident #20, and the order should have been verified prior to administering the medication. Review of the facility policy with an approval date of August 2022 titled Documentation of Medication Administration revealed all medications administered by a nurse or Certified Medication Aide should be documented on the MAR. 3. Interview on 01/06/26 at 10:55 A.M. with Resident #20 revealed she had not received her morning medications yet, including a water pill for swelling in both lower legs. Resident #20 stated she went (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to therapy right after breakfast. Review of the January 2026 MAR for Resident #20, on 01/06/26 at 10:57 A.M. revealed Resident #20's morning medications were marked off with a check mark, indicating the medications were dispensed and administered, including Bumetanide (a diuretic) tablet 2 mg ordered for congestive heart failure/lymphedema. Interview on 01/06/26 at 11:22 A.M. with Licensed Practical Nurse (LPN) #684 confirmed she pulled Resident #20's medications from the medication cart, charted in the electronic medical record to indicate the medications were administered, then realized Resident #20 was not in her room and was unable to administer the medications. LPN #684 confirmed the charting indicated Resident #20 had received her medications; however, LPN #684 showed the cup of Resident #20's medications remained in the medication cart awaiting administration. Review of the policy, Medication Administration, approved 04/2024, revealed the individual administering the medication must initial in the resident's MAR on the appropriate line after giving each medication and before administering the next ones.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the psychotropic consent forms, the facility failed to ensure residents and/or their representatives were informed of and consented to the use of psychotropic medications prior to administration. This affected five residents (#113, #3, #5, #4 and #49) of five residents reviewed for unnecessary medications. The facility census was 122. Findings include: 1. Review of Resident #113's medical record revealed an admission date of 09/21/25 and a discharge date of 01/08/26. Diagnoses included adjustment disorder, Parkinson's disease, type II diabetes, dementia with mood disorder, immunodeficiency due to medications (cancer medications), major depressive disorder, and general anxiety disorder. Review of Resident #113's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 indicating Resident #113 was moderately cognitively impaired. Resident #113 required maximal assistance with toilet use, bathing, and dressing. Resident #113 displayed no behaviors at the time of the review. Review of Resident #113's care plan revised 12/30/25 revealed supports and interventions for chronic confusion related to dementia, risk for adverse effects from psychotropic medication use, short term stay for rehabilitation therapy, depression, anxiety, altered sensory perception, self-care deficit, pain, and COVID-19. Review of Resident #113's physician orders revealed an order dated 09/21/25 for Duloxetine HCl (hydrochloride) (anti-depressant) delayed release sprinkles 60 milligrams (mg) in the morning for mood. Further review of Resident #113's physician orders found an order dated 09/21/25 for Olanzapine (antipsychotic) 7.5 mg at bedtime for symptoms of anxiety and major depression related to diagnosis of Parkinson's disease. Review of Resident #113's Psychotropic Medication informed Consent dated 09/21/25 revealed Resident #113 Olanzapine 7.5 milligrams (mg) nightly was listed for consent. The consent form was not signed by Resident #113 or his representative. Registered Nurse (RN) #581 was the only signature on the form. Further review of Resident #113's Psychotropic Medication Informed Consent forms revealed there was no consent form signed for the use of Resident #113's Duloxetine HCl 60 mg in the morning for mood. Interview on 01/12/26 at 12:47 P.M. with Regional Nurse Registered Nurse #800 verified Resident #113's Olanzapine 7.5 mg consent was not signed by Resident #113 or his representative and there was not a consent completed for Resident #113's Duloxetine HCl sprinkles 60 mg. Interview on 01/12/26 at 12:58 P.M. with Registered Nurse #581, who had signed Resident #113's psychotropic medication consent form, verified consent from Resident #113 or his representative had not been acquired for his psychotropic medications. 2. Review of the medical record for Resident #3 revealed an admission date of 12/01/25 with diagnoses of left femur fracture, hypertensive heart disease and chronic kidney disease, dementia, heart failure, Alzheimer's disease, hyperparathyroidism, osteoporosis, and dependence on supplemental oxygen. Resident #3 discharged home on [DATE]. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive admission MDS assessment, dated 12/08/25, revealed Resident #3 had impaired cognition and received antipsychotics, and antianxiety and antidepressant medications. Review of the physician order initiated 12/01/25 and discontinued 01/05/26 revealed Resident #3 received Trazodone HCl (an antianxiety medication) oral tablet 50 mg once daily by mouth at bedtime for sleep. Review of the physician order initiated 12/01/25 revealed Resident #3 received buspirone HCl (an antidepressant) oral tablet 5 mg once, one tablet three times daily for anxiety. Review of the physician order initiated 12/01/25 and discontinued 12/03/25 revealed Resident #3 received Quetiapine Fumarate (an antipsychotic) 50 mg twice daily for anxiety. Review of the physician order initiated 12/03/25 revealed Resident #3 received Quetiapine Fumarate oral tablet 50 mg once daily at bedtime for anxiety. Review of the physician order initiated 12/03/25 revealed Resident #3 received Quetiapine Fumarate oral tablet 25 mg once daily for anxiety. Review of the physician order initiated 01/05/26 revealed Resident #3 received trazodone HCl oral tablet 50 mg, 1.5 tablets by mouth at bedtime for sleep. Review of the document Psychotropic Medication Informed Consent, dated 12/01/25, revealed a recommendation for Resident #3 to receive Seroquel (Quetiapine Fumarate) 50 mg twice daily. Further review of the form revealed no diagnoses were listed and no indications for use were included on the form. Additionally, the form did not include trazodone HCl or buspirone HCL, two additional psychotropic medications prescribed to, and received by, Resident #3. Review of the Medication Administration Record (MAR) for December 2025 and January 2026 revealed Resident #3 received the three psychotropic medications as ordered. Interview on 01/08/2026 at 11:31 A.M. with Unit Supervisor #568, and concurrent review of Resident #3's Psychotropic Medication Informed Consent, confirmed no indications for the use of Seroquel were listed, and the form did not include trazodone HCl or buspirone HCl. Interview on 01/08/26 at 3:51 P.M. with Regional Registered Nurse #800 confirmed all psychotropic medications should be listed on the consent form. 3. Review of Resident #5's medical record revealed an initial admission date of 11/17/25 and a re-admission date of 12/06/25. Diagnoses included unspecified mental disorder due to known physiological condition, unspecified lack of expected normal physiological condition, type two diabetes mellitus, gout, and hypertensive chronic kidney disease. Review of Resident #5's Medicare five-day MDS assessment dated [DATE] revealed a BIMS score of 01 which indicated Resident #5 had severely impaired cognition. Review of Resident #5's care plan that was initiated on 11/18/25 revealed Resident #5 had an alteration in cognitive status related to short and long-term memory loss with interventions that included monitoring for changes in cognitive patterns and to notify the physician of changes and to (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide verbal reminders and cues to assist Resident #5 in orientation. Review of Resident #5's face sheet revealed Resident #5 had two resident representatives and was not his own responsible party. Review of Resident #5's psychotropic medication informed consent signed on 12/07/25 revealed Resident #5 was admitted to the facility taking Seroquel (antipsychotic) 25 mg daily in the morning and 12.5 mg daily at bedtime by mouth. Furthermore, Resident #5 had electronically signed the psychotropic medication informed consent form. Interview on 01/12/26 at 10:24 A.M. with Regional Nurse/Registered Nurse #800 verified Resident #5 signed the psychotropic medication informed consent and should not have signed the form as one of his resident representatives should have. 4. Review of Resident #4's medical record revealed the resident was admitted [DATE] and had diagnoses that included, but were not limited to, severe bipolar disorder without psychotic features, depression, and insomnia. Review of Resident #4's quarterly MDS assessment, dated 11/08/25, revealed the resident was cognitively intact. The assessment indicated the resident received antipsychotic medication on a routine basis. Review of Resident #4's physician orders revealed they included orders for Quetiapine (antipsychotic) 25 mg for bipolar disorder (ordered 11/02/25), Aripiprazole (antipsychotic) 25 mg at bedtime for bipolar disorder (ordered 11/02/25), Sertraline (antidepressant) 50 mg daily for depression (originally ordered 11/18/25 at 25 mg daily), Ramelteon (Melatonin receptor agonist) 8 mg at bedtime for insomnia (ordered 11/02/25), and trazodone (antidepressant) 50 mg at bedtime for insomnia (ordered 11/02/25). Review of Resident #4's MAR for November and December 2025 and January 2026 (through 01/08/25), confirmed the aforementioned medications were administered as ordered. Review of Resident #4's comprehensive care plan further revealed the resident was at risk for depression and mood fluctuations, for which an intervention was listed to administer medications as ordered. The care plan identified a risk for adverse effects of the antipsychotic and antidepressant medication with interventions to monitor for such. Review of progress notes from Resident #4's psychiatric evaluation on 12/18/25, revealed the medications and potential side effects were discussed with the resident, and nursing staff were to obtain written consent from the resident. Further review of Resident #4's record revealed it contained a form titled, Psychotropic Medication Informed Consent, that was electronically signed by Resident #4 on 10/21/25. The form listed the prescribed medications as Ability (Aripiprazole), 15 mg daily for bipolar schizophrenia. No other medications were included on the form. Resident #4's record included a second copy of the consent form that was signed by Resident #4 on 11/02/25. The form was blank other than Resident #4's signature and date, and no medications or potential side effects were listed. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/08/26 at 3:50 P.M. with Regional Registered Nurse #800, confirmed the facility had not obtained consent for Resident #4's psychotropic medications. 5. Review of Resident #49's medical record revealed an admission date of 10/05/25. Diagnoses included amputation, osteomyelitis of the right ankle and foot, type II diabetes mellitus, and depression. Review of Resident #49's MDS dated [DATE] revealed the resident had an intact cognition. Antidepressant medication was administered daily. Review of Resident #49's medical record revealed a physician's order dated 10/05/25 for Fluoxetine (antidepressant) HCl 20 milligrams (mg) to be taken by mouth one time a day. Review of Resident #49's Psychotropic Medication Informed Consent form dated 10/05/25 revealed the resident was failed to be educated regarding Fluoxetine. The medication information, consent, resident/resident representative information was left blank, but a staff nurse had signed the form on 10/05/25 at 3:27 P.M. Interview with Resident #49 on 01/12/26 at 10:44 A.M. revealed he did not recall signing the consent form. Interview with Corporate Nurse #800 on 10/12/26 at 8:22 A.M. verified that Resident #49's Psychotropic Medication Informed Consent form was failed to be completed prior to administering the antidepressant medication. Review of the form titled Psychotropic Medication Informed Consent revealed each resident's medication is managed and monitored to improve their quality of life, functional capacity, promote or maintain their highest practicable mental, physical and psychosocial well-being. In some instances, this will include the use of psychotropic medication. Psychotropic medication intervention would only be initiated after nonpharmacological interventions were attempted and found to be ineffective.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to administer medications per physician orders. This affected three residents (#5, #20, and #125) of four residents reviewed for medication administration. The medication error rate was 21.43 percent with six errors for the 28 medication opportunities. The facility census was 122. Findings include: 1. Review of Resident #5's medical record revealed an admission date of 12/06/25. Diagnoses included hypertensive chronic kidney disease stage 3B, anxiety, non-ischemic myocardial injury, gout, and type II diabetes mellitus. Review of Resident #5's Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated Resident #5 had severely impaired cognition. Review of Resident #5's physician orders revealed an order initiated on 12/23/25 for a Depakote oral tablet delayed release 125 milligrams (mg) with instructions to give one tablet by mouth two times a day for agitation. Observation on 01/07/26 at 10:39 A.M. of Licensed Practical Nurse (LPN) #685 preparing medications for Resident #5 revealed LPN #685 did not prepare the Depakote. Concurrent interview with LPN #685 verified she was omitting the medication due to an inability to crush the pill. LPN #685 stated Resident #5 took his pills through his feeding tube. Review of Resident #5's Medication Administration Record (MAR) for the month of January revealed LPN #685 marked a 9 which indicates other and to see the nurses notes. Review of Resident #5's nurses notes revealed LPN #685 did not enter a nurses note regarding the omission of the Depakote. 2. Review of Resident #20's medical record revealed an admission date of 12/22/25. Diagnoses included acute kidney failure, cellulitis of the right lower limb, hypertensive heart disease, congestive heart failure, metabolic syndrome, chronic obstructive pulmonary disease, type II diabetes mellitus, and gastroesophageal reflux disease. Review of Resident #20's admission MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated Resident #20 had intact cognition. Review of Resident #20's physician orders revealed an order to give Bumetanide two mg with instructions to give one two mg tablet by mouth one time day for congestive heart failure/lymphedema. Further review of the physician orders revealed an order for Janumet oral tablet 50-500 mg with instructions to give one tablet by mouth two times a day for diabetes mellitus. Interview on 01/06/26 at 10:55 A.M. with Resident #20 revealed she had not received her morning medications yet, including Bumetanide used for swelling. Resident #20 stated she went to therapy right after breakfast. Observation of medication administration on 01/06/26 at 11:37 A.M. completed by LPN #684 revealed that the medications were administered at 11:43 A.M. LPN #684 also verified she was not giving the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Janumet due to the medication being unavailable as the previous nurse did not re-order the medication in time. 3. Review of the medical record for Resident #125 revealed the resident was originally admitted [DATE] and had diagnoses that included schizoaffective disorder; depressive type, adjustment disorder with mixed anxiety and depressed mood, adjustment insomnia, generalized anxiety disorder, and psychotic disorder with hallucinations. Review of Resident #125's quarterly MDS assessment, dated 10/22/25, revealed the resident had intact cognition. The assessment indicated the resident received antipsychotics on a routine basis. Review of Resident #125's physician orders revealed they included multiple medication orders, including one dated 05/26/25 for Aripiprazole (antipsychotic) 20 mg tablet, give one tablet once daily, and Aripiprazole 5 mg tablet, give one tablet once daily (to equal a total dose of 25 mg once daily) for schizoaffective disorder. The record also included an order dated 08/20/25 for Risperdal 1 mg tablet, give one tablet twice daily for schizoaffective disorder. Observation on 01/07/26 at 8:30 A.M. revealed that during the preparation of Resident #125's morning medications, LPN #685 was unable to locate the Aripiprazole 20 mg tablets and the Risperdal 1 mg tablets. During this observation, LPN #685 stated those medications could not be administered since they were unavailable. The nurse prepared and administered the Aripiprazole 5 mg tablet and confirmed that without the 20 mg tablet, Resident #125 received 5 mg of Aripiprazole instead of the ordered 25 mg dose. Subsequent review of Resident #125's medical record confirmed LPN #685 documented the Aripiprazole 20 mg tablet and Risperdal 1 mg tablet were not administered because they were unavailable. Interview on 01/12/26 at 9:35 A.M. with Regional Registered Nurse #800 further confirmed LPN #685 did not administer the Aripiprazole 20 mg tablet on the morning of 01/07/26, resulting in a dosage error since the order was for Aripiprazole 25 mg. The nurse further confirmed LPN #685 did not administer the Risperdal 1 mg tablet as ordered on the morning of 01/07/26. Interview on 01/12/26 at 10:36 A.M. with Registered Nurse Unit Supervisor #568, confirmed the facility's automated dispensing cabinet in the main storage room contained a supply of Aripiprazole for Resident #125. The nurse confirmed the full dose of the medication could have been administered on the morning of 01/07/26, had the administering nurse accessed it from the dispensing unit. Review of a policy titled, Administering Medications, dated April 2024, confirmed medications shall be administered in a safe manner, as prescribed.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. 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. 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. 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. 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. 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. Observation on 01/07/26 at 12:13 P.M. of Resident #80's meal plate, and concurrent interview with Interim Dietary Manager #708, confirmed no evidence of a bread serving was under the pureed meat on Resident #80's plate. 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. 3. Review of Resident #77's medical record revealed an admission date of 11/07/26. Diagnoses (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included diabetes mellitus type two, cardiomegaly, and morbid obesity. Review of Resident #77's 5-day admission MDS dated [DATE] revealed her cognition was intact. 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. 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. 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. 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. 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. 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. 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. 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.		

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on staff interview and policy review, the facility failed to ensure nurses dispensed and administered medications within appropriate standards of practice. This affected 12 residents (#16, #34, #35, #36, #46, #62, #70, #72, #85, #111, #125, and #126). The facility census was 122. Findings include: Interview on 01/06/26 at 11:22 A.M. with Licensed Practical Nurse (LPN) #684 revealed she was an agency nurse and arrived late for the shift on 01/06/26. LPN #684 stated she completed a medication pass in coordination with Medication Aide - Certified (MA-C) #653. LPN #684 stated she pulled the medications from the cart, charted the medications were administered, and handed the medications to MA-C #653 to administer to residents. Interview on 01/06/26 at 11:29 A.M. with MA-C #653 confirmed she assisted LPN #684 with a medication pass. Follow-up interview on 01/06/25 at 1:07 P.M. with MA-C #653 revealed she worked with LPN #684 during the morning medication pass on 01/06/26. MA-C #653 stated they were working together because LPN #684 arrived late for her shift. MA-C #653 stated LPN #684 pulled the medications from the cart and MA-C #653 administered the medications to the residents. MA-C #653 stated this occurred for 12 residents (#16, #34, #35, #36, #46, #62, #70, #72, #85, #111, #125, and #126). Interview on 01/07/26 at 9:30 A.M. with Regional Registered Nurse (RN) #800 revealed it was not a nursing standard of practice for a nurse to pull medications from the cart and another staff to administer the medications. Review of the policy, Medication Administration, approved 04/2024, revealed the individual administering the medication must initial in the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, resident interview, and review of facility policy the facility failed to ensure the proper use of personal protective equipment (PPE) during care of residents on isolation and in enhanced barrier precautions (EBP). This affected six residents (#15, #9, #94, #119, #82, and #72) of eight residents reviewed for infection control practices. The facility census was 122. Findings include: 1. Observation on 01/05/26 at 10:22 A.M. found Certified Nursing Assistant (CNA) #655 entered room [ROOM NUMBER] occupied by Resident #15. CNA #655 wore standard glasses, donned a gown, gloves, and an N-95 mask prior to entering the room. A sign was posted on the door indicating Resident #15 was on droplet precautions. The posting listed the required Personal Protective Equipment (PPE) when entering the room was gloves, gown, goggles, and an N-95 mask. CNA #655 did not apply goggles or any other eye protection over her standard glasses. CNA #655 did not disinfect her glasses after exiting the room. Interview on 01/05/26 at 10:26 A.M. with CNA #655 verified Resident #15 was on droplet isolation due to having COVID-19. CNA #655 also verified she had not applied goggles prior entering Resident #15's room. CNA #655 reported wearing standard glasses was sufficient eye protection when providing care for residents on droplet precautions. 2. Observation on 01/05/26 at 10:54 A.M. found CNA #655 entered room [ROOM NUMBER] occupied by Resident #82. CNA #655 again wore standard glasses, donned a gown, gloves, and an N-95 mask prior to entering the room. A sign was posted on the door indicating Resident #82 was on droplet precautions and required PPE when entering the room was gloves, gown, goggles, and an N-95 mask. CNA #655 did not disinfect her glasses after exiting the room. 3. Observation on 01/05/26 at 10:58 A.M. found CNA #655 entered room [ROOM NUMBER] occupied by Resident #9. CNA #655 again wore standard glasses, donned a gown, gloves, and an N-95 mask prior to entering the room. CNA #499 also entered room [ROOM NUMBER] and donned goggles, gown, gloves and an N-95. A sign was posted on the door indicating Resident #9 was on droplet precautions and required PPE when entering the room was gloves, gown, goggles, and an N-95 mask. Coinciding interview with CNA #655 verified Resident #82 and Resident #9 were on droplet isolation due to COVID-19. No goggle or eyeglass disinfection was observed. 4. Observation on 01/05/26 at 11:47 A.M. found CNA #647 entered room [ROOM NUMBER] to assist with resident care for Resident #94 and #119. Signs were posted indicating Resident #94 and #119 were on droplet precautions and required PPE when entering the room were gloves, gown, goggles, and an N-95 mask. CNA #647 was observed entering the room with a surgical mask only and her standard eyeglasses. CNA #647 donned a gown and gloves but not an N-95 mask or goggles. Interview on 01/05/26 at 11:51 A.M. with CNA #647 verified she had entered room [ROOM NUMBER], a room with COVID positive residents, with a surgical mask and her standard eyeglasses. CNA #647 stated her eyes nose and mouth were covered and an N-95 was advised for COVID rooms but not required. 5. Observation on 01/05/26 at 11:57 A.M. found CNA #647 entered into room [ROOM NUMBER] occupied by Resident #82 to respond to a call light. CNA #647 continued to wear a surgical mask and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her standard eyeglasses only when entering a droplet isolation/COVID room. 6. Observation on 01/05/26 at 12:02 P.M. found the Administrator in Training (AIT) #739 assisting with meal delivery. AIT #739 was observed changing into an N-95 mask from a surgical mask, donning a gown, gloves and goggles prior to entering room [ROOM NUMBER], occupied by Resident #9. Interview on 01/05/26 with AIT #739 verified Resident #9 in room [ROOM NUMBER] was on droplet isolation and to enter required an N-95, gown, gloves, and eye covering being either goggles or a face shield. AIT #739 reported shoe coverings were available but optional. Goggles were disinfected and hand hygiene was completed following removal of all PPE before exiting the room. 7. Observation on 01/05/26 at 12:12 P.M. found CNA #647 exited out of room [ROOM NUMBER] and changed her surgical mask. CNA #647 had not worn an N-95 when providing care to Resident #82. CNA #647 also at no time disinfected her standard eyeglasses after exiting droplet isolation rooms and no goggles were worn. Interview on 01/05/26 at 3:44 P.M. with Resident #9 in room [ROOM NUMBER] found him to be alert and aware. Resident #9 verified staff were not always wearing the necessary PPE when helping him with care. 8. Observation on 01/07/26 at 12:15 P.M. revealed CNA #647, wearing standard glasses, donning a gown, gloves, and an N-95 mask and entering a COVID isolation room occupied by Resident #9 to provide a meal tray. CNA #647 did not don goggles prior to entering the room and passing a meal tray. Interview on 01/07/26 at 12:16 P.M. with the Administrator and CNA #647 confirmed she was not wearing goggles before passing the meal tray. 10. Review of the medical record for Resident #72 revealed an admission date of 1/24/25. Diagnoses included dementia, depression, Alzheimer's disease, and long term use of anticoagulants. Review of the quarterly MDS assessment, dated 11/17/25, revealed Resident #72 had intact cognition (BIMS 13), used a walker and wheelchair for mobility and was dependent for personal hygiene. Review of Resident #72's care plan initiated on 01/27/25 and last revised on 12/04/25 revealed Resident #72 required EBP related to a urinary catheter and wounds. Interventions included staff to wear appropriate PPE as indicated when providing patient care, and to educate resident and caregiver on EBP precautions and appropriate PPE. Review of Resident #72's physician orders dated 12/05/25 revealed an order for enhanced barrier precautions every shift for wounds. Observation on 01/07/26 at 8:47 A.M. of Resident #72's wound measurements revealed Licensed Practical Nurse (LPN) Unit Supervisor #570, Registered Nurse (RN) Unit Supervisor #566, and Nurse Practitioner (NP) #850 to be present in the room for the wound measurement. All three staff present were wearing gloves and a surgical face mask but did not have on a gown. Interview on 01/07/26 at 8:52 A.M. with NP #850, LPN #570, and RN #566 verified all three staff members were not wearing the appropriate PPE for EBP when caring for Resident #72. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy with an approval date of July 2024 titled Enhanced Barrier Precautions revealed EBPs require the use of gown and gloves for high contact resident care activities such as dressing, changing briefs, assisting with toileting, and wound care.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, and staff interview, the facility failed to ensure a toilet raiser was provided for resident #130. This affected one (#130) of one resident reviewed for accommodation of needs. The facility census was 122. Findings include: Review of Resident #130's medical record revealed an admission date of 11/25/25. Diagnoses included hypertensive heart disease, acute pulmonary edema, unspecified atrial fibrillation, anxiety, depression, a non-pressure chronic ulcer of other part of right foot with fat layer exposed and a non-pressure chronic ulcer of the left thigh limited to breakdown of skin. Review of Resident #130's admission/Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #130 had intact cognition. Furthermore, Resident #130 was dependent for toileting hygiene and lower body dressing, required substantial or maximal assistance for sitting to standing, and required substantial or maximal assistance for toilet transfers which included the ability to get on and off a toilet or commode. Review of Resident #130's care plan initiated on 11/26/25 and last revised on 12/09/25 revealed Resident #130 required activities of daily living (ADL) assistance due to weakness related to heart failure with interventions that included the use of assistive devices to improve mobility and ADL independence as indicated and to encourage Resident #130 to complete ADL's as independently as possible within limitations of illness/acute process. Review of the Occupational Therapy (OT) evaluation and plan of treatment for Resident #130 revealed a new goal with a baseline date of 11/26/25 that stated Resident #130 will safely perform toileting tasks using a raised toilet seat/three in one commode and grab bars while maintaining respiration rate with a target date of 12/09/25. Further review revealed Resident #130 reported her prior living setting was a private residence where she utilized a raised toilet seat with grab bars. Review of the OT therapy progress report for Resident #130 revealed the goal to safely perform toileting tasks using a raised toilet/three in one commode and grab bars with modified independence while maintaining respiratory rate. The baseline-initiated goal date was 11/26/25, a previous initiated goal date of 12/15/25, and a current initiated goal date of 12/30/25. Interview on 01/06/26 at 9:21 A.M. with Resident #130 revealed she has asked multiple nurses, nurse aides, and physical and occupational therapists for a toilet raiser and no one would get one for her. Resident #130 could not recall any specific staff members she had asked for a toilet raiser but stated she had made it known to many people she needed one as she had always used one when she lived independently. Observation on 01/06/26 at 9:23 A.M. of Resident #130's bathroom revealed there was no toilet raiser present in the bathroom. Observation on 01/07/26 at 3:27 P.M. of Resident #130's bathroom revealed a toilet raiser was present on the toilet. Interview on 01/08/26 at 9:46 A.M. with the Director of Rehabilitation - Physical Therapy (DOR-PT) #552 revealed Resident #130 had a lot of room changes recently, possibly due to the COVID-19 outbreak in the facility. On 12/29/25, Resident #130 moved from room [ROOM NUMBER] to 237. On 01/01/26, Resident #130 moved from room [ROOM NUMBER] to 255. On 01/02/26, Resident #130 moved from room [ROOM NUMBER] to 127. DOR-PT #552 stated when Resident #130 lived upstairs, she had been in a room with another resident who had a toilet raiser and she used that one. DOR-PT #552 stated if the facility were to provide the raiser, it would be entered into the physician's orders by the physical therapist who initiated it. DOR-PT #552 stated a toilet raiser would not be an order from the physician; it is more-so something used to assist with toileting. DOR-PT #552 verified a toilet raiser would be considered an assistive device that may promote independence.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure Do Not Resuscitate (DNR) orders were signed in the medical record. This affected one (#50) of 24 residents reviewed for advanced directives. The facility census was 122. Findings include: Review of Resident #50's medical record revealed an admission date of [DATE]. Diagnoses included traumatic subarachnoid hemorrhage without loss of consciousness, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), dementia, and depression. Review of Resident #50's Medicare five-day Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 05 which indicated Resident #50 had severely impaired cognition. Review of Resident #50's physician orders revealed an order for code status; Do Not Resuscitate - Comfort Care Arrest (DNR-CCA) that was initiated on [DATE]. Review of Resident #50's care plan dated [DATE] revealed Resident #50 and her family had chosen a DNR-CCA order with interventions that included in the event of cardiac or respiratory arrest, do not initiate Cardiopulmonary Resuscitation (CPR) and obtain the appropriate DNR order. Observation on [DATE] at 2:50 P.M. revealed Resident #50's DNR-CCA form was not signed by the physician/Nurse Practitioner (NP). Interview on [DATE] at 2:25 P.M. with NP #501 revealed it was the responsibility of the NP to sign the DNR orders for the residents they saw. NP #501 verified there was no signature on Resident #50's DNR form and the pen marks at the bottom of the form were not her signature. NP #501 stated she had now signed the form, and it was placed back into the chart. Review of the facility policy with an approval date of [DATE] titled Advanced Directives revealed a DNR Order is a directive issued by a physician which states that a resident should not receive CPR.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, and policy review the facility failed to inform a resident of an impending room change. This affected one resident (#77) who was unexpectedly moved to a new room. This had the ability to affect all residents. The facility census was 122. Findings include: Review of medical record revealed Resident #77 was admitted on [DATE]. Diagnoses included osteoarthritis, diabetes mellitus, hepatomegaly, splenomegaly, and cardiomegaly. Review of Resident #77's 5-day admission Minimum Data Set (MDS) dated [DATE] revealed the resident's cognition was intact. Review of Resident #77's most recent care plan revealed that while in the facility choices were important to her. Review of Resident #77's progress note dated 01/02/26 at 11:15 A.M. revealed the resident was moved to room [ROOM NUMBER]-A with a report, medications, and chart were given to the nurse assigned. Interview with Resident #77 on 01/05/26 at 10:36 A.M. revealed she was moved from her room on the second floor without a choice to the room on the first floor on 01/02/26 without proper notification. The resident denied the move was COVID related. Interview with Licensed Social Worker (LSW) #557 on 01/12/26 at 9:24 A.M. verified that the resident's chart was absent of documentation regarding notification of a room move on 01/02/26. LSW #557 revealed all residents and families were normally notified prior to a room move. Review of the facility policy titled Room Change Policy dated November 2000 revealed following the decision of a room move the social worker or designee will follow up with the appropriate parties as needed including the resident and the resident representative to ensure that they are in agreement with the plan.		

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NAME OF PROVIDER OR SUPPLIER Kingston Health Center of Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE 4121 King Road Sylvania, OH 43560	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to monitor the use of psychotropic medications to confirm they were necessary. This affected one resident (Resident #4) of five residents reviewed for unnecessary medications. The census was 122. Findings include: Review of Resident #4's medical record revealed the resident was admitted [DATE] and had diagnosis that included insomnia. Review of Resident #4's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/08/25, revealed the resident was cognitively intact. The assessment indicated Resident #4 had reported trouble falling asleep, staying asleep, or sleeping too much, on 12 to 14 days of the two-week assessment period. Review of Resident #4's physician orders revealed they included an order for trazodone hydrochloride (an antidepressant) 50 milligrams (mg) daily at bedtime, and an order for Ramelteon (a Melatonin receptor agonist) 8 mg daily at bedtime. Both orders were dated 11/02/25 and both orders specified the medications were ordered to treat insomnia. Review of Resident #4's Medication Administration Records (MAR) for 11/01/25 through 01/12/26, confirmed the trazodone and Ramelteon were administered at bedtime every night as ordered. Review of Resident #4's comprehensive care plan revealed it included neither the diagnosis of insomnia, nor any goals or interventions, including but not limited to, the routine administration of the two medications ordered specifically for insomnia, and/or monitoring of the resident's sleep patterns to support the use of those two medications. Further review of Resident #4's medical record, including nurse and Certified Nursing Assistant (CNA) documentation, further confirmed the facility was not monitoring the resident's sleep patterns. Interview on 01/12/26 at 9:35 A.M. with Regional Registered Nurse #800 confirmed Resident #4's record did not include documented monitoring of the resident's sleep patterns, to support the use of the two routine psychotropic medications administered to Resident #4 for insomnia.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of policy for care planning, the facility failed to develop a care plan for a diagnosis of insomnia. This affected one resident (Resident #4) of 23 residents reviewed for care planning. The census was 122. Findings include: Review of Resident #4's medical record revealed the resident was admitted [DATE] and had diagnosis that included insomnia. Review of Resident #4's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/08/25, revealed the resident was cognitively intact. The assessment indicated Resident #4 had reported trouble falling asleep, staying asleep, or sleeping too much, on 12 to 14 days of the two-week assessment period. Review of Resident #4's physician orders revealed they included an order for trazodone hydrochloride (an antidepressant) 50 milligrams (mg) daily at bedtime, and an order for Ramelteon (a Melatonin receptor agonist) 8 mg daily at bedtime. Both orders were dated 11/02/25 and both orders specified the medications were ordered to treat insomnia. Review of Resident #4's Medication Administration Records (MAR) for 11/01/25 through 01/12/26, confirmed the trazodone and Ramelteon were administered at bedtime every night as ordered. Review of Resident #4's comprehensive care plan revealed it included neither the diagnosis of insomnia, nor any goals or interventions, including but not limited to, the routine administration of the two medications ordered specifically for insomnia. Interview on 01/12/26 at 9:35 A.M. with Regional Registered Nurse #800 confirmed Resident #4's comprehensive care plan did not include the diagnosed insomnia, nor a goal(s) or interventions for such, despite the facility administering trazodone and Ramelteon routinely to Resident #4. Review of a policy titled, Care Planning - Interdisciplinary Team, dated December 2021, confirmed a comprehensive care plan shall be developed within seven days of the comprehensive assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure dependent residents received adequate activities of daily living care. This affected one Resident (#77) for toenail care and one Resident #72 for fingernail care. This had the ability to affect all residents. The facility census was 122. Findings include: 1. Review of Resident #77's medical record revealed an admission date of 11/07/26. Diagnoses included osteoarthritis, type II diabetes mellitus, and a history of lower leg cellulitis. Review of Resident #77's 5-day admission Minimum Data Set (MDS) dated [DATE] revealed the resident had an intake cognition. The resident required substantial assistance with rolling left and right and lying to sitting. Review of Resident #77's most recent care plan revealed the resident required assistance with activities of daily living related to weakness, low hemoglobin, and osteoarthritis in bilateral knees. Staff assistance was required for dressing and grooming. Review of Resident #77's medical record revealed a physician's order dated 11/07/25 revealed the resident may have dental, podiatry, optometry, or psychiatry consult as needed. Review of a social service progress note dated 12/22/25 revealed a referral was sent to podiatry. Observation on 01/07/25 at 9:10 A.M. of Resident #77's toenails revealed the right great toenail was extremely thick and long. The nail was grown approximately one inch past the top of her toe and curled inward. The second toe on the left foot was viewed the same. All other toenails were longer than the resident wished and thick. Interview with Resident #77 on 01/07/26 at 9:10 A.M. revealed she had asked to see the podiatrist on admission but had not. The resident revealed due to having the diagnosis of diabetes mellitus the staff refused to trim her toenails. Interview with Certified Nursing Assistant (CNA) #620 on 01/08/26 at 7:38 A.M. verified Resident #77's toes nails were very long, thick, and flaky and in need of seeing the podiatrist. CNA #620 stated staff do not trim resident toenails if they have a diabetic diagnosis. Interview with Licensed Social Worker (LSW) #557 on 01/12/26 at 9:24 A.M. verified the she was unaware that Resident #77 had asked to see podiatry on admission, was not informed by nursing that the resident was in need, and but the referral was placed. The resident was on the podiatrist list for the next visit. 2. Review of the medical record for Resident #72 revealed an admission date of 1/24/25 with diagnoses of dementia, depression, Alzheimer's disease, and long-term use of anticoagulants. Review of the quarterly MDS assessment, dated 11/17/25, revealed Resident #72 had intact cognition and was dependent for personal hygiene. Review of the comprehensive care plan, initiated 01/27/25, and revised 01/12/26, revealed Resident #72 required assistance with activities of daily life due to fluctuating cognition and end of life hospice care. Interventions included encouraging Resident #72 to complete activities of daily life as independently as possible. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/07/26 at 4:14 P.M. with CNA #642, and concurrent observation of Resident #72's fingernails, revealed Resident #72's fingernails were very long, extending well beyond her fingertips, were painted red, and had debris under most of them. CNA #642 stated Resident #72 was unable to feed herself. CNA #642 further stated when she tried to clean Resident #72's nails in the past, Resident #72, who had difficulty expressing herself, acted like the cleaning hurt. Interview on 01/12/26 at 9:25 A.M with CNA #651, and concurrent observation of Resident #72's fingernails, revealed Resident #72's fingernails were long, extending well beyond her fingertips, and the sides of the fingernail at the edge of the fingertip were curving and pressing into the skin at the sides of the fingertips. This was observed and confirmed on her left hand for the ring finger, middle finger, and pointer finger; and on her right hand for the ring finger, middle finger, and thumb. CNA #651 confirmed there was debris under the fingernails, but also stated it appeared the skin was bunched up under the fingernails. Further observation revealed no broken skin or open wounds on Resident #72's fingers. Review of the facility policy titled Care of Fingernails/Toenails dated May 2023 revealed the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes regular cleaning and regular trimming. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, resident review, and policy review, the facility failed to ensure nursing staff assessed wounds accurately. This affected Resident #123 and had the potential to affect 31 residents (#1, #6, #12, #15, #20, #27, #33, #36, #38, #49, #51, #57, #59, #68, #72, #87, #89, #95, #97, #99, #103, #104, #112, #120, #123, #124, #127, #129, #137, #140, and #141) identified with wounds. Additionally, the facility failed to ensure a resident did not receive food in preparation for a scheduled medical test. This affected one (#4) of one resident reviewed for medical testing. The facility census was 122. Findings include: 1. Review of the medical record for Resident #123 revealed an admission date of 04/12/15 with diagnoses of anxiety, chronic respiratory therapy, depression, embolism and thrombosis. Resident #123 was under the care of hospice. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/25, revealed Resident #123 had impaired cognition, was dependent on staff for bed mobility, and was at risk for developing pressure ulcers. No pressure ulcers were identified at the time of the assessment. Review of Resident #123's weekly skin assessments, titled Non-Pressure Injury Review, dated 11/19/25, revealed a right buttock wound, described as end of life skin failure measured 8 centimeters (cm) long by 5 cm wide by 2 cm deep. Review of the Non-Pressure Injury Review, dated 11/25/25, revealed Resident #123's right buttock wound measurement stated 10 cm by 6 cm by 0.1 cm (total area). Review of the Non-Pressure Injury Review, dated 12/09/25, revealed Resident #123's right buttock wound, measured 9 cm by 5.2 cm. Review of the Non-Pressure Injury Review, dated 12/16/25, revealed Resident #123's right buttock wound measured 8 cm by 5 cm. Review of the Non-Pressure Injury Review, dated 12/23/25, revealed Resident #123's right buttock wound measured 8 cm by 5 cm by less than 0.1 cm. No assessment was completed 12/30/25. Review of the Non-Pressure Injury Reviews, dated 01/06/26, revealed Resident #123's right buttock wound measured 1.4 cm by 4 cm by 0.1 cm. Interview on 01/07/26 at 10:07 A.M. with Unit Supervisor (US) #566 confirmed she remeasured a wound on Resident #72, another resident diagnosed with an end of life skin failure, after an agency floor nurse measured it incorrectly. Interviews on 01/08/26 at 2:17 P.M. and 3:26 P.M. with Unit Supervisor/Wound Nurse (USWN) #570 revealed she completed the assessment and measurement of Resident #123's wound on 01/06/26. USWN #570 stated Resident #123 was under the care of hospice, and her wound was not considered a pressure ulcer; therefore, facility floor nurses were assigned the task of measuring and assessing her wound. USWN #570 stated she was assigned the task of doing weekly rounds with the Wound Provider on Tuesdays for residents with pressure ulcers. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview regarding the discrepancy in measurements between 12/23/25 and 01/06/26, USWN #570 stated the nurses conducting the assessments may have measured the whole darkened area; whereas the wound measurements should only reflect the open area of the wound. Additionally, USWN #570 stated the floor nurses may have not oriented their measurements correctly to the head-to-toe of the resident; suggesting the measurements taken on 12/23/25 of 8 cm by 5 cm by 0.1 cm may more likely have been 5 cm by 8 cm by 0.1 cm. Additionally, USWN #570 stated she found discrepancies in the way nurses were measuring wounds since she began the position as wound nurse approximately three months previously. Review of the policy, Wound and Skin Management, approved 09/2024, revealed Charge/Staff Nurse to complete Non-Pressure Skin Condition Record every week; and staff education on skin and wound practice guidelines with pressure injuries and wound/skin conditions upon orientation and annually at a minimum. 2. Review of Resident #4's medical record revealed the resident was admitted [DATE] and had diagnoses that included type II diabetes mellitus and dysphagia (difficulty swallowing). Review of Resident #4's quarterly MDS assessment, dated 11/08/25, revealed the resident was cognitively intact. Review of Resident #4's comprehensive care plan revealed it identified a potential for an altered nutrition and/or hydration status, due in part, to the diagnosis of dysphagia. Review of Resident #4's physician orders revealed they included an order for a National Dysphagia Diet (NDD); Level 3 (to include moist, soft foods) with nectar-thick liquids. The record further included an order for an Esophagogastroduodenoscopy (EGD). This test, which uses a flexible scope to examine the esophagus, stomach, and small intestine, was scheduled to be performed 01/08/26 at an area hospital. Included with this order, dated 01/07/26, was an order for the resident to have nothing by mouth after midnight, in preparation for the EGD. Review of a nurse's progress note dated 01/08/26, revealed Resident #4 was provided with a breakfast tray on this date, and the resident ate the meal. The progress note stated the nurse notified the outpatient survey center which canceled the procedure and rescheduled it for 01/30/26. Interview on 01/12/26 at 9:25 A.M. with Regional Registered Nurse #800 confirmed Resident #4 was provided a breakfast meal on the morning of 01/08/26, thereby necessitating the EGD to be rescheduled. The nurse stated the kitchen is typically made aware of such orders and will hold the breakfast meal, which did not happen in this case. The nurse further confirmed Resident #4's EGD was rescheduled for 01/30/26 (22 days later).		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, staff interview, and policy review, the facility failed to ensure pressure-reducing devices were in place. This affected two (#28 and #123) of six residents reviewed for skin breakdown. The facility census was 122. Findings include: 1. Review of the medical record for Resident #28 revealed an admission date of 12/22/25 with diagnoses of atrial fibrillation, dementia, and Raynaud syndrome. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 12/29/25, revealed Resident #28 had impaired cognition and required substantial/maximal assistance for bed mobility. Further review revealed Resident #28 was at risk for developing pressure injuries. Review of the current care plan, initiated 12/22/25, revealed Resident #28 was at risk for impaired skin integrity. Interventions, initiated 12/23/25, revealed staff should off-load Resident #28's heels while in bed. Review of the physician order dated 12/23/25 revealed Resident #28 was to wear heel lift boots to both lower extremities when in bed. Observation on 01/05/26 at 2:07 P.M. revealed Resident #28 lying in bed. A pair of offloading boots were sitting on the shelf opposite her bed. Interview on 01/05/26 at 2:15 P.M. with Certified Nursing Assistant (CNA) #628 confirmed Resident #28 was not wearing the offloading boots. CNA #628 stated he believed the boots were used when Resident #28 was in bed for the night, and did not offer to place them on Resident #28's feet when he laid her in bed for a nap. Concurrent review of the electronic medical record (EMR) for Resident #28 revealed CNA #628 confirmed Resident #28 had an order to wear heel lift boots when in bed. 2. Review of the medical record for Resident #123 revealed an admission date of 04/12/15 with diagnoses of anxiety, chronic respiratory therapy, depression, embolism and thrombosis. Resident #123 was under the care of hospice. Review of the quarterly MDS assessment, dated 11/13/25, revealed Resident #123 had impaired cognition, was dependent on staff for bed mobility, and was at risk for developing pressure ulcers. No pressure ulcers were identified at the time of the assessment. Review of the physician order dated 10/06/25 revealed Resident #123 should have heel lift boots on as tolerated while in bed for skin integrity. Review of the physician order dated 10/06/25 revealed Resident #123 should offload heels when in bed if resident tolerates or will allow. Review of the current care plan, revised 01/06/26, revealed Resident #123 was at risk for impaired skin integrity related to total dependence for care. Interventions include off-loading heel boots as tolerated. Observation on 01/05/2026 at 2:28 P.M. and concurrent interview with Unit Supervisor (US) #566 revealed Resident #123 lying in bed. Offloading boots were observed on a shelf in the room. US #566 confirmed Resident #123 was not wearing offloading boots. Continued interview, with concurrent review of the EMR, revealed US #566 confirmed Resident #123 had a physician order to wear heel lift boots, as tolerated, while in bed for skin integrity. US #566 proceeded to ask Resident #123 if US #566 could place offloading boots on her heels and Resident #123 was agreeable. Review of the policy Wound and Skin Management Protocol, approved 09/2024, revealed the facility would implement preventative interventions (to protect skin integrity) immediately upon admission.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, resident interview, and policy review, the facility failed to ensure tube feedings were administered per the physician's orders and per professional nursing standards of practice. This affected one (#5) of one resident review for tube feeding. The facility census was 122. Findings include: Review of Resident #5's medical record revealed an admission date of 12/06/25. Diagnoses included hypertensive chronic kidney disease stage 3B, anxiety, non-ischemic myocardial injury, gout, and type two diabetes mellitus. Review of Resident #5's Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 01 which indicated Resident #5 had severely impaired cognition. Furthermore, Resident #5 was dependent for eating and all mobility. Review of Resident #5's care plan with a date initiated of 12/06/25 revealed Resident #5 required a tube feeding to maintain adequate nutrition and hydration with interventions that included to check the residual every shift and as needed, tube feeding formula/rate as ordered, and to elevate the head of the bed over 30 degrees. Observation on 01/07/26 at 10:45 A.M. of Licensed Practical Nurse (LPN) #685 administering medications via the gastrostomy (stomach feeding) tube (g-tube) revealed LPN #685 verified placement of the tube by pushing 10 milliliters (ml) of air into the tube and listening for the air with a stethoscope. LPN #685 then began to administer the crushed Tylenol dissolved in water by sucking the Tylenol from the medication cup with a syringe, placing the syringe into the g-tube, unclamping the g-tube, and pushing the Tylenol into the tube. After pushing the Tylenol, LPN #685 stated I know to check for gastric residual volume (GRV), just pretend I did that. Without removing the syringe from the residents g-tube, LPN #685 then pulled the plunger out of the syringe. Resident #5 was repeatedly stating he was sensitive. LPN #685 re-assured Resident #5 that tube feedings should not hurt. LPN #685 then began to administer the crushed Metoprolol dissolved in water by sucking the Metoprolol from the medication cup with a syringe, placing the syringe into the g-tube, unclamping the g-tube, and pushing the Metoprolol into the tube. Interview on 01/07/26 at 10:57 A.M. with LPN #685 verified she had only given Resident #5 medications through his g-tube and had not given him any bolus feedings that shift. Interview on 01/07/26 at 11:17 A.M. with Resident #5 revealed he was very hungry. Resident #5 stated no one had fed him breakfast this morning. Interview on 01/07/26 at 11:20 A.M. with LPN #685 verified Resident #5's breakfast tray was on his overbed stand and the food was untouched by Resident #5. Interview on 01/07/26 at 11:21 A.M. LPN #685 stated she was not aware Resident #5 received bolus tube feeding but now was aware and she was preparing to administer the feeding. LPN #685 stated she would mark the scheduled 08:00 A.M. tube feeding as omitted due to time restraints and administer the tube feed now. LPN #685 verified she was running behind and the patient load is too much. She stated she normally does not push medications or anything with the plunger when administering through a g-tube. LPN #685 stated she usually would check residual but she was rushed by the patient assignment. LPN #685 stated she would not normally pull back the plunger when the syringe is in the tube. LPN #685 stated she would put the syringe in the tube and pour the medications in. Review of the facility policy with an approval date of March 4th, 2025 titled Enteral Tube Feeding via Continuous Pump revealed to check the GRV. If stomach content cannot be aspirated, pull back slightly on the tube to reposition. If the tube is still not patent, withhold medication and notify the physician.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to ensure medications were administered per physician orders. This affected one (#3) of seven residents reviewed for medication administration. The facility census was 122. Findings include: Review of the medical record for Resident #3 revealed an admission date of 12/01/25 with diagnoses of hypertensive heart disease and chronic kidney disease, dementia, and heart failure. Resident #3 discharged home on [DATE]. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 12/08/25, revealed Resident #3 had impaired cognition and received antipsychotics, and antianxiety and antidepressant medications. Review of the physician order initiated 12/01/25 and discontinued upon discharge on [DATE], revealed Resident #3 received Lisinopril (a blood pressure lowering medication) oral tablet 40 milligrams (mg), one tablet daily for hypertension; hold for SBP (systolic blood pressure) less than 100 millimeters of Mercury (mmHg). Review of Resident #3's blood pressure on 12/22/25 revealed it was 90/62 mmHg. Review of Resident #3's blood pressure on 01/05/26 revealed it was 94/52 mmHg, on 01/06/26 it was 99/70 mmHg, and on 01/08/26 it was 91/57 mmHg. Review of Resident #3's Medication Administration Record (MAR) for December 2025 revealed she received Lisinopril on 12/22/25. Review of Resident #3's MAR for January 2026 revealed she received Lisinopril on 01/05/26, 01/06/26, and 01/08/26. Interview on 01/08/26 at 3:50 P.M. with Regional Registered Nurse (RRN) #800 confirmed Resident #3 received Lisinopril when Resident #3's SBP was less than 100 on four occasions, 12/22/25, 01/05/26, 01/06/26, and 01/08/26. Review of the policy, Administering Medications, approved 04/2024, revealed medications must be administered in accordance with the orders.		

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 Health 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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, medical record review, staff interview, and review of policy for medication storage, the facility failed to label insulin injector pens with open dates. This affected three residents (Residents #5, #20, and #148). The facility identified 22 residents with current orders for insulin injections. Further, the facility failed to properly store medications during the medication administration process. This affected one resident (Resident #20) of four residents observed during medication administration. The census was 122. Findings include: 1. Review of Resident #5's medical record revealed an admission date of 12/06/25 with diagnoses that included type II diabetes mellitus. Review of Resident #5's physician orders revealed they included an order for insulin Glargine (Lantus) solution via pen injector, inject 35 units every 12 hours for diabetes. Observation on 01/12/26 at 10:47 A.M. of the C-2 Hall medication cart, revealed it contained an insulin Glargine pen injector for Resident #5, with approximately 70 units of insulin remaining. The pen injector was not marked with an open date. Review of manufacturer instructions at www.lantus.com confirmed the insulin Glargine pen injector should be discarded within 28 days after opening, if it is not refrigerated. 2. Review of Resident #20's medical record revealed an admission date of 12/22/25 with diagnoses that included type II diabetes mellitus. Review of Resident #20's physician orders revealed they included an order for insulin Lispro (Humalog) solution via pen injector per sliding scale for diabetes. Observation on 01/12/26 at 10:47 A.M. of the C-2 Hall medication cart, revealed it contained an insulin Lispro pen injector for Resident #20, with approximately 230 units of insulin remaining. The pen injector was not marked with an open date. Review of manufacturer instructions at www.pi.lilly.com confirmed the insulin Lispro pen injector should be discarded within 28 days after opening, if it is not refrigerated. 3. Review of Resident #148's medical record revealed a most recent admission date of 01/02/26 with diagnoses that included type II diabetes mellitus. Review of Resident #148's physician orders revealed they included an order for insulin aspart (Novolog) solution via pen injector, inject 3 units before meals along with an additional dosage based on a sliding scale for diabetes. Observation on 01/12/26 at 10:47 A.M. of the C-2 Hall medication cart, revealed it contained an insulin aspart pen injector for Resident #148, with approximately 75 units of insulin remaining. The pen injector was not marked with an 'open' date. Review of manufacturer instructions at www.novolog.com confirmed the insulin aspart pen injector (continued on next page)		

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 Health 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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be discarded within 28 days after opening, if it is not refrigerated. Interview on 01/12/26 during these observations with Registered Nurse #577 confirmed the aforementioned insulin pen injectors were not marked with 'open' dates. Review of a policy titled, Storage of Medications, dated 01/07/24, confirmed nursing staff shall not use outdated or deteriorated drugs or biologicals. 4. Review of the medical record for Resident #20 revealed an admission date of 12/22/25 with diagnoses of cellulitis of right lower limb, hypertensive heart disease, congestive heart failure, metabolic syndrome, chronic obstructive pulmonary disease, and type II diabetes mellitus. Review of the comprehensive admission MDS assessment, dated 12/29/25, revealed Resident #20 had intact cognition. Interview on 01/06/26 at 10:55 A.M. with Resident #20 revealed she had not received her morning medications yet, including a water pill for swelling in both lower legs. Resident #20 stated she went to therapy right after breakfast. Review of the January 2026 MAR for Resident #20, on 01/06/26 at 10:57 A.M. revealed Resident #20's morning medications were marked off with a check mark, indicating the medications were dispensed and administered, including Bumetanide (a diuretic) tablet 2 mg ordered for congestive heart failure/lymphedema. Interview on 01/06/26 at 11:22 A.M. with Licensed Practical Nurse (LPN) #684 revealed she was an agency nurse and completed the morning medication pass with the assistance of Medication Aide Certified (MA-C) #653. LPN #684 could not verify whether she dispensed and administered Resident #20's morning medications until she spoke with MA-C #653. Continued interview on 01/06/26 at approximately 11:26 A.M. with LPN #684, after LPN #684 spoke with MA-C #653, confirmed LPN #684 pulled Resident #20's medications, then realized Resident #20 was not in her room and was unable to administer the medications. LPN #684 confirmed the charting indicated Resident #20 had received her medications; however, LPN #684 showed the cup of Resident #20's medications remained in the top drawer of the medication cart awaiting administration. LPN #684 confirmed seven medications were in an unlabeled medication cup. Review of the policy, Storage of Medications, approved 01/07/24, revealed drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.		