STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365646	a. building _____ b. wing _____	04/04/2025

name of provider or supplier	street address, city, state, zip code
KINGSTON OF ASHLAND	20 AMBERWOOD PKWY ASHLAND OH, 44805

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F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00163865 COMPLAINT NUMBERS OH00163859 AND OH00162280 ADMINISTRATOR: Heather Eckert, #7363 CERTIFIED BED CAPACITY: 110 CENSUS IN HOUSE: 92 The following deficiencies are based on the complaint investigation completed on 04/04/2025.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

RACHEL.MAMERE1 | 04/18/2025

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.

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F 0697	Continued From page 1	F 0697		
F 0697 SS=G	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This STANDARD is not met as evidenced by: Based on medical record review, interviews with staff, and facility policy review, the facility failed to ensure a comprehensive post-surgical pain management program was maintained to achieve adequate pain control for Resident 93. This resulted in Actual Harm on 03/07/25 at 1:38 A.M. when Resident #93, who had a surgical amputation of the left leg (below the knee) on 02/22/25 and had an order for Oxycodone 10 milligrams (mg) immediate release every four hours for moderate pain, complained of severe post-operative pain rated at a 10 out of 10 (on a 0-10 pain scale with 0 representing no pain and 10 representing the worst pain the resident had ever experienced); however, the resident's Oxycodone had not been reordered timely, resulting in no narcotic pain medication available for administration and the resident had to be transferred to the emergency room to receive pain medication. This affected one (Resident #93) of two residents reviewed for pain management. The facility census was 92.	F 0697	This Plan of Correction is being prepared and executed because it is required by the provisions of the State and Federal regulations and not because Kingston of Ashland agrees with the allegations and citations listed on the statement of deficiencies. Kingston of Ashland maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Kingston of Ashland written credible allegations of compliance. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Kingston of Ashland reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction 4/17/2025 as the facility's credible allegation of compliance. F697 Resident #93 no longer resides in the center. Resident #93 was sent to the ER on 3/7 and script for Percocet obtained at that time. Nurse practitioner #339 was provided education on 4/3 and 4/4 on the pain assessment and management policy, controlled substance prescription policy and receiving controlled substances policy. Director of nursing or designee will review current residents on narcotic pain medications to ensure that the narcotic medication regimen is effective for treating pain and that the narcotic pain medications are available for use. This will be completed on or before 4/17/2025. Issues identified will be addressed at time of discovery. Director of Nursing or	04/17/2025

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F 0697	Continued From page 2 Findings Include: Review of the medical record for Resident #93 revealed an admission date on 02/26/25 and a discharge date on 03/11/25 with the diagnoses including but not limited to surgical amputation of the left lower leg below the knee, chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), and high blood pressure. Review of the physician orders for Resident #93 revealed an order dated 02/26/25 for narcotic pain medication Oxycodone 10 mg immediate release tablet, take one tablet by mouth (PO) every four hours as needed (PRN) for moderate pain, and an order dated 02/26/25 for acetaminophen (Tylenol) oral tablet 325 mg, give three tablets by mouth every eight hours for moderate pain. Review of the admission assessment dated 02/26/25 revealed Resident #93 reported a pain level of six out of 10 on admission. Further review of Resident #93's admission baseline care plan dated 02/26/25 revealed Resident #93 was at risk for pain related to surgical procedure of left leg below the knee amputation with interventions including medications as ordered, repositioning and elevation as needed. Review of the Medicare 5-Day Minimum Data Set (MDS) assessment dated 03/05/25 revealed Resident #93 had	F 0697	designee will educate licensed nurses and Certified Medication Aides on the controlled substance prescription policy and receiving controlled substance policy which includes reordering of controlled medications on or before 4/17/2025. Director of Nursing or designee with educated licensed nurses on the pain assessment and management policy on or before 4/17/2025. Director of Advanced Nurse practitioners will educate the nurse practitioners on the controlled substance prescription policy and receiving control substance policy which includes reordering of controlled medications on or before 4/17/2025. Director of nursing or designee will complete audit on 5 residents weekly for 4 weeks that receive narcotic pain medications to ensure that the narcotic medication regimen is effective for treating pain and that narcotic pain medication is available for use. The results will be presented to the QAA committee for review and consideration for further corrective actions.	

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F 0697	Continued From page 3 intact cognition. Resident #93 required moderate assistance from staff for transfers, mobility, and personal hygiene care. Resident #93 received scheduled and as needed pain medication and Resident #93 had experienced pain five days out of the seven days during the review period. Review of the medication administration record (MAR) dated 02/26/25 to 03/06/25 revealed Resident #93 had received the as needed narcotic pain medication Oxycodone 10 mg for a total of 17 doses for pain levels ranging from 7 to 10 with the follow up assessment being marked as effective for pain management of Resident #93. Resident #93 was also receiving scheduled acetaminophen (Tylenol) oral tablet 325 mg, give three tablets by mouth every eight hours for moderate pain. Review of Resident #93's progress note authored by Registered Nurse (RN) #337 dated 03/07/25 at 1:38 A.M. revealed Resident #93 was yelling and moaning complaining of severe pain. Resident #93 requested narcotic pain medication. RN #337 received in report Resident #93's narcotic pain medication Oxycodone prescription had not been renewed with the pharmacy. RN #337 notified on-call Nurse Practitioner (NP) #339 to request the prescription be renewed. NP #339 denied the request to renew the prescription and instead gave an order for extra strength Tylenol stating will not be	F 0697		

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F 0697	Continued From page 4 giving narcotic orders at 2:00 A.M. RN #337 informed NP #339 Resident #93 would be transferred to the hospital for pain control if requested. Review of Resident #93's progress note authored by RN #337 dated 03/07/25 at 1:41 A.M. revealed Resident #93 was offered the extra strength Tylenol for pain control, Resident #93 denied the medication and requested to be transferred to the hospital. RN #337 called emergency medical services (EMS) for transport of Resident #93 to the hospital. Resident #93 left the facility at 1:50 A.M. with EMS. Review of the hospital discharge paperwork for Resident #93 dated 03/07/25 at 2:55 A.M. revealed hospital diagnoses for Resident #93 was postoperative pain with new orders including Oxycodone - Acetaminophen (Percocet) 5-325 mg per tablet, give one tablet by mouth every six hours as needed for pain and an order for Gabapentin (Neurontin) 400 mg give one capsule by mouth three times daily. Review of the MAR dated 03/07/25 to 03/11/25 for Resident #93 revealed Resident #93 received Percocet 5-325mg for a total of three doses with pain level ranging from five to seven out of 10 on the pain scale. The follow up documentation revealed the medication was effective in controlling Resident #93's pain.	F 0697		

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F 0697	Continued From page 5 Interview on 03/25/25 at 10:15 A.M. with RN #337 revealed because Resident #93's prescription for Oxycodone 10 mg had not been renewed, the pharmacy would not give the authorization for RN #337 to remove the narcotic pain medication from the facility's emergency medication machine for administration. Interview on 03/25/25 at 1:00 P.M. with the Director of Nursing (DON) confirmed Resident #93's narcotic pain medication prescription for Oxycodone 10 mg had not been renewed with the pharmacy and was unavailable when Resident #93 was experiencing a severe pain level of 10 on 03/07/25 resulting in Resident #93's transfer to the hospital for pain management. The DON stated the original prescription for Resident #93 had been written for a total of 18 doses and expired on 03/06/25 with the facility not attempting to renew the prescription for Resident #93. Multiple attempts were made on 03/26/25 during the onsite survey to contact NP #339; however, there was no return contact made with the surveyor. Review of the facility's policy titled Pain Assessment and Management undated revealed "pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment	F 0697		

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F 0697	Continued From page 6 goals. This deficiency represents non-compliance investigated under Complaint Number OH00163865.	F 0697		

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F 0760	Continued From page 7	F 0760		
F 0760 SS=G	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This STANDARD is not met as evidenced by: Based on review of medical records, interviews with staff and residents, facility policy review, and medication manufacturer guidelines review, the facility failed to ensure residents were free of significant medication errors. This resulted in actual harm for one resident on 02/16/25 at 7:23 P.M. when Resident #111, who received long-acting insulin and blood glucose monitoring for the management of Type II diabetes, was administered insulin despite a physician order to hold the insulin when the blood glucose level was below 200 milligrams per deciliter (mg/dL) of blood. The resident's blood glucose level was 109 mg/dL (normal range is 70-100 mg/dL). The resident experienced hypoglycemia (low blood glucose level) with a blood glucose level of 44 mg/dL at 1:30 A.M. and was unresponsive. Resident #111 required the administration of glucagon (injection medication to treat hypoglycemia) and emergency medical transport observation until the resident was stable and hourly blood glucose checks per glucometer to monitor and prevent reoccurrence. Additionally, two other residents (#302 and #404) were placed at risk for the potential for more than minimal harm when their physician	F 0760	This Plan of Correction is being prepared and executed because it is required by the provisions of the State and Federal regulations and not because Kingston of Ashland agrees with the allegations and citations listed on the statement of deficiencies. Kingston of Ashland maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Kingston of Ashland written credible allegations of compliance. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Kingston of Ashland reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction 4/17/2025 as the facility's credible allegation of compliance. Resident #111 was treated at the time of the error in the center with no outstanding negative outcomes noted after treatment for low blood sugar. Resident #111 was assessed by nurse at time of change in condition on 2/17/2024 with blood sugars being checked hourly until blood sugars were within normal range. Resident #111 assessed by CNP on 2/24/2025. Resident #111 remains in the center. Resident #404's Lasix order was corrected at the time of discovery with no negative outcome noted. Resident #404 was assessed at the time of discovery by nurse on 2/24/2025. Resident #404 was assessed by CNP on 2/25/2025. Resident #404 remains in the center. Resident #302's had no negative	04/17/2025

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F 0760	Continued From page 8 ordered medications were not administered as prescribed. This affected three (#111, #302 and #404) of five residents reviewed for medication errors. Findings Include: 1. Review of the medical record for Resident #111 revealed an admission date on 04/29/23 with diagnoses including but not limited to Type II diabetes, high blood pressure, asthma, depression, and anxiety. Review of Resident #111's at risk care plan dated 09/03/24 revealed Resident #111 was at risk for fluctuating blood glucose levels related to diagnosis of Type II diabetes with interventions including regularly monitoring blood glucose levels and administering medications as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated 01/04/25 revealed Resident #111 had mild cognitive impairment with a Brief Interview of Mental Status score of 12 out of possible 15. Resident #111 had impairment to one side and required limited assistance from staff for personal care, transfers, and medication administration. Resident #111 received insulin injections for seven days during the review period. Review of physician orders for Resident #111 revealed an order dated 02/05/25 for insulin Lantus Solution pen-injector 100	F 0760	outcome related to being administered another resident's medications. Resident #302 was assessed at the time of discovery by the nurse on 3/14/2025. Resident #302 remains in the center Director of nursing or designee will review current residents with orders for insulin to ensure that the medication is being given per order. This will be completed on or before 4/17/2025. Issues identified will be addressed at time of discovery. Director of nursing or designee will review medication orders for residents that have been admitted since date of survey exit through date of compliance to ensure that medication orders were transcribed appropriately upon admission. This will be completed on or before 4/17/2025. Issues identified will be addressed at the time of discovery. Director of nursing or designee will complete medication administration observations on current residents to ensure that medications are given per order. This will be completed on or before 4/17/2025. Issues identified will be addressed at the time of discovery. Director of Nursing or designee will educate licensed nurses and certified medication aides on the administering medications policy on or before 4/17/2025. Director of Nursing or designee will educate licensed nurses on the electronic order entry process and transcription policy on or before 4/17/2025. Director of nursing or designee will complete audit on 5 residents weekly for 4 weeks that receive insulin to ensure medication was given per order. Director of nursing or designee will complete medication order audit on 5 new admissions weekly for 4 weeks to ensure that medication orders are	

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F 0760	Continued From page 9 unit/milliliter (ml) inject 55 units subcutaneous (SQ) at bedtime (HS) for glucose control - hold if below (blood glucose level) 200. Blood glucose monitoring four times a day (breakfast, lunch, dinner and bedtime). Insulin Aspart 100 units per ml, give 30 units with all meals. Review of Resident #111's blood glucose results dated 02/16/25 at 7:23 P.M. revealed the result was recorded as 109 mg/dL (the physician orders indicated the resident's Lantus insulin [long-acting insulin which peaks three to four hours after administration]) was to be held (not administered). Review of the February 2025 Medication Administration Record (MAR) for Resident #111 revealed on 02/16/25 at 8:30 P.M., Registered Nurse (RN) #337 administered 55 units of Lantus Insulin to Resident #111. Review of Resident #111's progress note dated 02/17/25 at 1:30 A.M., revealed the resident was observed to be unresponsive and slouching to the right, with their tongue hanging out of their mouth. The resident's blood glucose result was 44 mg/dL of blood per glucometer. The on-call nurse practitioner (NP) was notified, and an order was received for Glucagon 1 milligram (mg) intermuscular and to send Resident #111 to the hospital if needed.	F 0760	transcribed appropriately upon admission. Director of nursing or designee will complete medication administration observations on 5 residents weekly for 4 weeks to ensure that medications are given per order. The results will be presented to the QAA committee for review and consideration for further corrective actions.	

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F 0760	Continued From page 10 Review of Resident #111's progress note dated 02/17/25 at 1:35 A.M. revealed Glucagon 1 mg was administered via intermuscular injection to the left deltoid. Review of Resident #111's progress note dated 02/17/25 at 1:50 A.M. revealed emergency medical services (EMS) were called for transport of Resident #111 to the hospital. Review of Resident #111's progress note dated 02/17/25 at 1:55 A.M. revealed EMS arrived at the facility. Resident #111 remained unresponsive. Blood glucose obtained with result of 65 mg/dL. EMS attempted to initiate intravenous (IV) access and was not successful. Review of Resident #111's progress note dated 02/17/25 at 2:05 A.M. revealed Resident #111 was awake, alert and eating a peanut butter and jelly sandwich. Re-check of blood glucose level with a result of 85 mg/dL. Review of Resident #111's progress note dated 02/17/25 at 2:10 A.M. revealed a recheck of the blood glucose with a result of 98 mg/dL. EMS stated Resident #111 was stable and left the facility. Resident #111 was not transported to the hospital. Review of Resident #111's progress note dated 02/17/25 at 3:47 A.M. revealed the on-call NP was notified Resident #111 remained in the facility with a new order received to obtain blood glucose every	F 0760		

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F 0760	Continued From page 11 hour. Resident #111 and son were notified of the new order. Review of Resident #111's progress note dated 02/17/25 at 7:00 A.M. revealed Resident #111's vital signs were blood pressure 108/70 mmHg (normal 120/60 mmHg), pulse 57 beats per minute (normal range 60-90 bpm), temperature 97.4 degrees Fahrenheit, respirations 18 breaths per minute (normal 12-20 breaths per minute), blood glucose 196 mg/dL. On call NP notified with new order to hold insulin dosage for breakfast. Review of Resident #111's progress note dated 02/17/25 at 10:36 A.M. revealed the NP was notified of Resident #111's blood glucose reading of 249 mg/dL and ordered to continue to hold the resident's insulin. Resident #111 was more alert and talkative and consumed 95% of the breakfast meal. Hourly blood glucose monitoring was discontinued at 8:00 A.M. Review of the facility's medication error report dated 02/17/25 and completed by RN #337 revealed Resident #111 was administered 55 units of Lantus Insulin on 02/16/25 at bedtime. Resident #111's blood glucose reading was 109 mg/dL. The physician order was for Lantus insulin with parameters to hold the insulin if the blood glucose results were below 200 mg/dL. Further review of the February 2025 MAR revealed the resident's scheduled insulin	F 0760		

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F 0760	Continued From page 12 was resumed on 02/18/25. An interview on 03/24/25 at 3:25 P.M. with Resident #111 revealed Resident #111's blood glucose results fluctuate a lot and usually will be low instead of being high. Resident #111's diabetes is monitored by a specialist. An interview on 03/25/25 at 12:47 P.M. with the Director of Nursing confirmed RN #337 had administered Lantus insulin to Resident #111 when the blood glucose result was 109 mg/dL which was below the parameters set for the administration of the Lantus insulin. This resulted in a significant medication error. The resident's Lantus insulin was ordered to be held for a blood glucose level of less than 200 mg/dL, and it wasn't. The resident developed hypoglycemia which warranted the administration of Glucagon and more frequent blood glucose monitoring due to low blood sugar. Review of the facility's policy titled Administering Medications dated 04/01/24 revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the physician orders, including any required time frame. Review of the manufacturer guidelines for Insulin Glargine (Lantus) revealed the onset of action for Lantus insulin is three to four hours after administration with no	F 0760		

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F 0760	Continued From page 13 pronounced peak effect. 2. Review of the medical record for Resident #302 revealed an admission date of 12/22/23 with diagnoses including right femur fracture, COPD, high blood pressure, atherosclerotic heart disease, and hyperlipidemia. Review of the physician orders for Resident #302 revealed an order dated 09/03/24 for an antiplatelet medication Clopidogrel Bisulfate (Plavix) 75 mg give one tablet by mouth in the morning for atherosclerotic heart disease, and an order dated 09/03/24 for antihypertensive medication Carvedilol (Coreg) 3.125 mg give one tablet by mouth every morning and at bedtime for high blood pressure. Review of the quarterly Minium Data Set (MDS) assessment dated 02/19/25 revealed Resident #302 had cognitive impairment with a BIMS score of 12 out of possible 15 and required assistance from staff for personal hygiene care and medication administration. Review of Resident #302's progress note dated 03/14/25 at 9:20 A.M. revealed Resident #302 had been administered the wrong morning medications during morning medication pass by LPN #330. LPN #330 had administered a lower dose of Coreg and a dose of the anticoagulant medication, Eliquis, to Resident #302 (these medications were not ordered for the resident). Resident #302's vital signs	F 0760		

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name of provider or supplier	street address, city, state, zip code
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F 0760	Continued From page 14 were stable and there was no sign of bleeding. Resident #302's daughter was notified, and the on-call NP was notified. Review of the facility's medication error report dated 03/14/25 completed by LPN #330 revealed Resident #302 had received Resident #300's Eliquis and Coreg medications during the morning medication administration. Resident #302 had a head-to-toe assessment completed by LPN #330 with no negative findings documented. Resident #300's morning medications were removed from the facility's emergency medication machine and administered per physician order. An interview on 03/25/25 at 1:20 P.M. with the DON confirmed on 03/14/25 Resident #302 had been administered Resident #300's morning medications including the anticoagulant Eliquis and high blood pressure medication, Coreg. The DON stated the expectation of the facility nurses was to accurately read the physician orders and check the medications with the resident's MAR and name prior to administration of the medications. Review of the facility's policy titled Administering Medications dated 04/01/24 revealed medications ordered for a particular resident may not be administered to another resident. The individual administering the medications must verify the resident's identity before giving the resident his/her medications.	F 0760		

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F 0760	Continued From page 15 3. Review of the medical record for Resident #404 revealed an admission date on 01/31/25 with a readmission date from the hospital on 02/20/25. The resident had diagnoses including but not limited to diverticulitis of the large intestine, arterial fibrillation (AFib), heart failure, chronic kidney disease Stage 3, Type II diabetes, and peripheral vascular disease (PVD). Review of Resident #404's Medicare 5 - Day MDS assessment dated 02/06/25 revealed Resident #404 had impaired cognition with a BIMS score of 11 out of 15. Resident #404 required assistance from staff for personal care, transfers, and medication administration. Resident #404 was receiving diuretic medication and heart failure was marked as a diagnosis. Review of the hospital discharge paperwork and physician orders for Resident #404 dated 02/20/25 revealed an order for Furosemide oral tablet (Lasix) 20mg, give one tablet two times per week. Review of Resident #404's physician orders revealed an order dated 02/24/25 for diuretic medication Furosemide oral tablet (Lasix) 20 mg, give one tablet by mouth in the morning every Monday, Thursday, and Saturday for heart failure. Further review revealed a discontinued order dated 02/20/25 to 02/24/25 for	F 0760		

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F 0760	Continued From page 16 diuretic medication Furosemide oral tablet (Lasix) 20 mg, give one tablet twice a day for heart failure. Review of Resident #404's MAR dated 02/20/25 to 02/24/25 revealed Resident #404 had been administered Furosemide 20mg, two times per day for a total of four days. Review of Resident #404's progress note dated 02/24/25 at 12:10 P.M. authored by LPN #217 revealed the order for Furosemide 20 mg and been clarified and changed to administration two times per week instead of two times daily. Review of the facility's medication error report completed by LPN #217 revealed Resident #404's discharged physician order from the hospital dated 02/20/25 for Furosemide 20 mg had been transcribed incorrectly instead of being administered two times weekly, the order had been transcribed to be administered two times per day with Resident #404 receiving the Furosemide 20 mg two times per day for four days resulting in a significant medication error. An interview on 03/25/25 at 8:50 A.M. with LPN #217 revealed on 02/24/25 LPN #217 was reviewing Resident #404's recent laboratory results with NP #312 which indicated abnormal results with kidney function. LPN #217 reviewed Resident #404's hospital discharge medication orders dated 02/20/25 and	F 0760		

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F 0760	Continued From page 17 saw where the Furosemide 20 mg order had been transcribed incorrectly in Resident #404's medical record. NP #312 clarified Resident #404's Furosemide order and LPN #217 updated the Furosemide order to reflect Furosemide 20mg to be administered two times per week. An interview on 03/25/25 at 1:10 P.M. with the DON confirmed Resident #404's hospital discharge order for Furosemide 20 mg, give one tablet by mouth two times per week had been transcribed incorrectly into Resident #404's medical record for Furosemide 20 mg to be given two times daily resulting in a significant medication error. The DON stated the expectation of the facility nurses is to accurately read the physician orders and check the medications with the resident's MAR and name prior to administration of the medications. Review of the facility's policy titled administering medications dated 04/01/24 revealed medications shall be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00163865.	F 0760		

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F 0842	Continued From page 18	F 0842		
F 0842 SS=E	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting	F 0842	This Plan of Correction is being prepared and executed because it is required by the provisions of the State and Federal regulations and not because Kingston of Ashland agrees with the allegations and citations listed on the statement of deficiencies. Kingston of Ashland maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Kingston of Ashland written credible allegations of compliance. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Kingston of Ashland reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction 4/17/2025 as the facility's credible allegation of compliance. Resident #348's orders for ergocalciferol and calcitriol were corrected at the time of discovery with no negative outcome noted. Resident #348 no longer resides in the center. Director of nursing or designee will review medication orders for residents that have been admitted since date of survey exit through date of compliance to ensure that medication orders were transcribed appropriately upon admission. This will be completed on or before 4/17/2025. Issues identified will be addressed at the time of discovery. Director of Nursing or designee will educate licensed nurses on electronic order entry process and transcription policy on or before 4/17/2025. Director of nursing or	04/17/2025

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F 0842	Continued From page 19 of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes;	F 0842	designee will complete medication order audit on 5 new admissions weekly for 4 weeks to ensure that medication orders are transcribed appropriately upon admission. The results will be presented to the QAA committee for review and consideration for further corrective actions.	

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F 0842	Continued From page 20 and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This STANDARD is not met as evidenced by: Based on medical record review, interview and facility policy review the facility failed to maintain accurate medical records by not transcribing physician orders correctly. This deficient practice affected one resident (Resident #348) out of five residents reviewed for medication errors. The facility census was 92. Findings Include: Review of the medical record for Resident #348 revealed admission date on 02/22/25 with diagnoses including but not limited to high blood pressure, type two diabetes, Congestive Heart Failure (CHF), and osteoporosis. Review of the hospital discharge orders dated 02/22/25 for Resident #348 revealed an order for Ergocalciferol oral capsule 1.25 milligrams (mg) (50,000 units) give one capsule orally in the morning every Monday for supplemental use. Review of the physician orders for Resident #348 revealed an order dated 02/22/25 for a vitamin D2 supplement Ergocalciferol oral capsule 1.25 milligrams (mg) (50,000 units) give one capsule orally in the morning for	F 0842		

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F 0842	Continued From page 21 supplemental use (daily). Review of the Medication Administration Record (MAR) dated 02/22/25 to 02/28/25 revealed the order for Ergocalciferol oral capsule 1.25 milligrams (mg) (50,000 units) give one capsule orally in the morning (daily) for supplemental use was marked as being administered on 02/23/24 in the morning. Further review of the MAR revealed on 02/24/25 the order was marked as not administrated by Licensed Practical Nurse (LPN) #217. An interview on 03/25/25 at 8:05 A.M. with LPN #217 revealed on 02/24/25 during the morning medication administration for Resident #348 LPN #217 recognized the order for Ergocalciferol oral capsule 1.25 milligrams (mg) (50,000 units) had been transcribed incorrectly during Resident #348's admission process on 02/22/25. LPN #217 notified the physician for clarification and entered the correct order for Ergocalciferol oral capsule 1.25 milligrams (mg) (50,000 units) give one capsule orally in the morning every Monday for supplemental use. An interview on 03/25/25 at 1:18 P.M. with the Director of Nursing (DON) confirmed Resident #348's order for vitamin D2 supplement Ergocalciferol had been incorrectly transcribed during Resident #348's admission process on 02/22/25. A review of the facility's policy titled Administering Medications dated 02/01/23	F 0842		

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F 0842	Continued From page 22 revealed medications shall be administered in a safe and timely manner, and as prescribed. This deficiency represents non-compliance investigated under Complaint Number OH00163865	F 0842		