| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366305 | A. Building<br>B. Wing | 06/08/2023 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528<br><br>Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure residents were provided with clean linen. This affected one (Resident #70) of three residents reviewed for a clean and sanitary environment. The facility census was 113.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #70 was admitted on [DATE]. Diagnoses included localization related symptomatic epilepsy and epileptic syndromes with complex partial seizures, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease, major depressive disorder, and hyperlipidemia.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 was cognitively intact.<br><br>Review of the progress note dated 06/01/23, revealed Resident #70 had a mole noted to his back area. There was bloody drainage coming from under the mole. The physician provided a one time treatment ordered and advised the mole would be removed the next day.<br><br>Review of progress note dated 06/02/23, revealed Resident #70 had the mole removed from back.<br><br>Interview on 06/06/23 at 11:34 A.M. with Resident #70 revealed a mole was removed from his back last Friday (06/02/23), which had caused a bloody drainage stain on his bed linens. Resident #70 stated he had asked twice over the weekend for his bed sheets to be changed due to the stains.<br><br>Observation on 06/06/23 at 11:35 A.M. revealed Resident #70's white bed linen had four obvious pink colored stains.<br><br>Observation on 06/07/23 at 11:45 A.M. revealed Resident #70's white bed linen had four obvious pink colored stains with no change from the day prior.<br><br>Interview on 06/07/23 at 11:55 A.M. with State tested Nursing Assistant (STNA) #438 verified Resident #70's bed sheets had apparent blood stains and were in need of being changed. |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528<br><br>Based on medical record review, observation, resident interview, staff interview and review of facility policy, the facility failed to ensure a resident's personal hygiene needs were met. This affected one (Resident #58) of one resident reviewed for activities of daily living. The facility census was 113.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #58 was admitted on [DATE]. Diagnoses included peripheral vascular disease, dementia in other diseases classified elsewhere, type two diabetes mellitus with diabetic chronic kidney disease, Parkinson's disease, hyperlipidemia, and anxiety disorder.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #58 was moderately cognitively impaired and required extensive one person assistance with dressing and personally hygiene and extensive two person assistance with bed mobility, dressing, and toilet use. Resident #58 required two person total dependence for transfers and total dependence one person for locomotion on and off unit.<br><br>Review of the care plan dated 10/18/22 and updated 06/08/23, revealed Resident #58 required assistance with Activities of Daily Living (ADLs) with interventions including the resident often refuses oral care and/or gets tired while completing tasks and to encourage the resident to complete to the highest level of ability. Staff were to offer assistance as needed, including applying toothpaste, holding toothbrush, and brushing teeth.<br><br>Review of personal hygiene: self performance tracking documentation dated 05/10/23 to 06/08/23, revealed Resident #58 required extensive assistance to total dependence with personal hygiene.<br><br>Interview on 06/05/23 at 11:54 A.M. Resident #58 reported his teeth had not been brushed for one to two months, and would like his teeth brushed. Subsequent observations revealed Resident #58 had yellow built-up film covering his teeth.<br><br>Interview on 06/07/23 at 1:43 P.M. with Resident #58 revealed his teeth had not yet been brushed. Subsequent observation revealed Resident #58 had yellow built-up film covering his teeth.<br><br>Interview on 06/07/23 at 1:47 P.M. with State tested Nursing Assistant (STNA) #319 verified she provided care to Resident #58 and did not brush his teeth that day.<br><br>Observation on 06/07/23 at 1:55 P.M. revealed STNA #319 in Resident #58's room preparing supplied to brush the resident's teeth. STNA #319 was able to locate his toothbrush but not toothpaste. STNA #319 obtained a new bottle of toothpaste and placed the toothbrush with toothpaste in Resident #58's hand. Resident #58 was observed to have difficulty holding and positioning the toothbrush at a comfortable angle. STNA #319 offered Resident #58 assistance in brushing his teeth and Resident #58 readily agreed. STNA #319 was observed to brush Resident #58's teeth.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's policy, Teeth Brushing, approved September 2021 revealed a resident should be assisted with brushing his or her teeth based on individual needs. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure auto-lock brakes were applied to a resident's wheelchair as ordered to potentially prevent falls. This affected one (Resident #41) of three residents reviewed for falls. The facility census was 113.<br><br>Findings include:<br><br>Review of Resident #41's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, respiratory failure, type II diabetes mellitus, heart disease, heart failure, history of falling, and dysphagia.<br><br>Review of Resident #41's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed the resident was cognitively impaired. The resident required extensive assistance of two staff for the majority of activities of daily living.<br><br>Review of Resident #41's active physician orders identified an order dated 01/03/23 for auto-lock brakes to wheelchair.<br><br>Review of Resident #41's plan of care dated 09/05/20 and revised 03/21/23, revealed the resident was at risk for falls related to a history of falls and confusion. The goal was for the resident, responsible party, and staff to develop and implement strategies to promote safety, mitigate injuries, and reduce the potential for falls. Interventions included auto-lock brakes to wheelchair, which was initiated on 02/06/23.<br><br>Observation on 06/06/23 at 10:42 A.M. of Resident #41 revealed the resident was sitting in her wheelchair in her room. There were no auto-lock brakes in place on the resident's wheelchair<br><br>Observation and interview on 06/06/23 at approximately 10:55 A.M. with Registered Nurse #450 and Licensed Practical Nurse #284 verified Resident #41 did not have auto-lock brakes on her wheelchair. At the time of interview, staff reported the brakes may have been taken off previously when an intravenous therapy pole was placed on the resident's wheelchair.<br><br>Review of the facility policy titled, Managing Fall and Fall Risk, dated November 2019, revealed based on assessments, previous evaluations and current data, the staff will identify intervention related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on observation, medical record review, staff interview, facility pain clinical protocol and manufacture owners manual, the facility failed to ensure pain control interventions were monitored for effectiveness. This affected one resident (#52) reviewed for pain control interventions. Facility census 113.<br><br>Findings include:<br><br>Medical record review revealed Resident #52 admitted to the facility on [DATE] with diagnoses including, cerebral infarction with hemiplegia and hemiparesis affecting left non-dominant side, hypertension, anxiety, osteoporosis, and depression.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact, dependent on staff for the completion of activities of daily living, dependent on staff for bed mobility and transfer, and received as needed pain medications.<br><br>Further review of the medical record revealed on 05/08/23, a nursing plan of care was implemented to address Resident #52's pain related to osteoporosis. Interventions included the following; assess pain at least daily, attempt non-pharmacologic interventions for pain management as indicated or appropriate (distraction, repositioning, massage, cryotherapy), evaluate effectiveness of pain interventions, and monitor response to pain prevention/interventions and document as indicated.<br><br>Review of Resident #52's physician orders revealed an order dated 05/23/23 for morphine sulfate (pain medication) five milligrams by mouth every six hours as needed for pain. On the following days and times the resident was noted to receive the medication: 06/02/23 at 4:36 P.M. for a pain level of 9 (on a scale of 1 [no pain] to 10 [extreme pain]), 06/03/23 at 8:10 P.M. pain scale of 6, 06/04/23 at 8:32 P.M. pain scale of 4, 06/05/23 at 3:00 A.M. pain scale of 10, 06/05/23 at 8:25 P.M. pain scale of 8, and 06/06/23 at 6:59 P.M. pain scale of 8.<br><br>Further review of physician orders revealed an order dated 05/24/23 for an air mattress due to the resident being bedbound. Review of the Treatment Administrator Record revealed the air mattress was documented in place at 7:00 A.M. each day. Further review of the medical record revealed no identification of settings.<br><br>Observation on 06/05/23 at 10:57 A.M. noted Resident #52 in bed with an air mattress in place. Resident #52 stated the air mattress was not inflated and she was not comfortable. The resident indicated the air mattress had not been operational for an undetermined amount of time, possibly days. Further observation noted the air lines kinked between the bed frame and lift mechanism. The air mattress power control unit was affixed to the foot board and equipped with audible and visual alarm indicators. However, the alarm indicators were not illuminated or indicating the air mattress was malfunctioning.<br><br>At 11:02 A.M. interview and observation with Registered Nurse (RN) #416 confirmed the air mattress was not operational or inflating as designed with the air hose supply and return hoses kinked in the bed frame.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 06/07/23 at 8:35 A.M. revealed Resident #52 in bed with the air mattress operational. Resident #52 verbalized discomfort and indicated she was positioned in a hole. The resident also stated nursing staff was unaware how to utilize the air mattress effectively.<br><br>On 06/07/23 at 8:38 A.M. interview with Licensed Practical Nurse (LPN) #437 revealed being responsible for Resident #52's medication delivery. LPN #437 stated this was their first day working at facility as an agency nurse and was unaware of Resident #52's pain interventions including air mattress application or settings. At 8:45 A.M. interview with Unit Manager Licensed Practical Nurse (LPN) #290 revealed residents on air mattresses are checked each shift to ensure they are in place. However, the air mattresses are set up by a durable medical equipment company most times and no instruction was given on how to ensure they are operated in accordance with manufacturer instructions. LPN #290 went on to indicate physician orders many times do not indicate specific settings for their intended use.<br><br>On 06/08/23 at 9:30 A.M. interview with the Director of Nursing verified there was no documentation contained in Resident #52's medical record indicating the operation and effective adjustments to address the comfort level for the air mattress. Additionally, no education was provided to the resident to ensure optimal comfort and assistance with pain relief.<br><br>Review of the undated air mattress owners manual revealed air lines are not to be threaded through mechanical parts and check to be sure the motion of the bed does not interfere with the air lines. Comfort level selection allows selection of air cylinder firmness. Begin in softest setting, then adjust for comfort as desired.<br><br>Review of the facility pain clinical protocol revised April 2007 revealed the physician will order appropriate non-pharmacologic and medication interventions to address the individuals pain. Staff will provide elements of a comforting environment and appropriate physical and complimentary interventions; for example local heat or ice, repositioning, massage, and opportunity to talk about chronic pain. The staff will discuss significant changes in levels of comfort with the physician and may include medication adjustments or possible addition of non-pharmacologic interventions. |