

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2016
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NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: January 4, 5, 6, 7 and 8, 2016</p> <p>Facility number: 000522 Provider number: 155479 AIM number: 100267040</p> <p>Census bed type: SNF: 32 SNF/NF: 78 Total: 110</p> <p>Census payor type: Medicare: 30 Medicaid: 64 Other: 16 Total: 110</p> <p>These deficiencies reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on January 11, 2016 by 17934.</p>	F 0000	<p>Enclosed is the plan of correction for the survey completed at Kingston Care Center on 01-08-16. Please consider this the facility's credible allegation of compliance. However, submission of this response and the plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission of interest against the facility, the administrator or any employees, agent, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Rather, this plan of correction has been prepared because the law requires us to prepare a plan of correction for the citations regardless of whether we agree with them. Kingston Care Center is respectfully requesting that a desk review be done for the plan of correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 0332 SS=E Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the medication administration error rate did not exceed 5% for 4 of 26 medication administration opportunities observed, which resulted in an error rate of 15.4%. (Resident #33, 218, 237 and 105)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An observation of the medication pass on 1-6-2016 at 10:47 a.m. (the actual time of the injection), indicated LPN (Licensed Practical Nurse) #11 administered a Humalog injection (a rapid acting insulin) of 56 units subcutaneously to Resident #33. Further observation indicated Resident #33 was not served her lunch meal until 11:15 a.m. in the Crown dining room. 2. An observation of the medication pass on 1-6-2016 at 5:00 p.m. (the actual time of the injection), indicated RN (Registered Nurse) #12 administered a Humalog injection of 4 units subcutaneously to Resident #237. Further observation indicated Resident #237 was not served her evening meal 	F 0332	Resident#33, #218, #237 and #105 did not experience a negative outcome. Residents that receive rapid acting insulin or a medication that should be administered with meals will be offered a snack consisting of but not limited to lemon cookie, chocolate cookie, or applesauce at the time of medication administration. Snack acceptance or refusal will be recorded. The Director of Nursing Services and/or designee will train nurses on offering and documenting snack acceptance by 1/20/2016. The Director of Nursing Services and/or designee will complete random audits that snacks are being offered and acceptance documented. Audits will be completed 3 times a week for 2 weeks, weekly for 2 weeks, every 2 weeks for 8 weeks, and monthly for 3 months with results discussed at monthly quality assurance meeting. Alleged date of compliance is 2/1/2016.	02/01/2016

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	<p>until 5:37 p.m. in the Crown dining room.</p> <p>3. An observation of the medication pass on 1-7-2016 at 10:40 a.m. (the actual time of the injection), indicated RN #10 administered a Humalog injection of 3 units subcutaneously to Resident #218. Further observation indicated Resident #218 was not served her lunch meal until 11:08 a.m.</p> <p>4. An observation of the medication pass for Resident #105 on 1-6-2016 at 4:30 p.m., indicated RN #9 administered Macrochantin (an antibiotic) 50 mg (milligram) capsule by mouth without food. RN #9 was observed to tell the resident the evening meal would be served in 30 minutes.</p> <p>A review of the most recent physician's recapitulation provided on 1-8-2016 at 12:50 p.m. by the Director of Nursing (DON), indicated the order as "Macrochantin Capsule 50 MG Give 50 mg by mouth one time a day...Take 50 mg PO (by mouth) with evening meal...."</p> <p>An interview with LPN #13 on 1-8-2016 at 10:55 a.m., indicated a meal should be served within 30 minutes to a resident who had received Humalog insulin injection.</p>			

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	<p>An interview with LPN #11 on 1-8-2016 at 11:00 a.m., indicated a meal should be served within 10 to 15 minutes to a resident who had received Humalog insulin.</p> <p>An interview with the DON on 1-8-2016 at 12:00 p.m., indicated residents who received an insulin such as Humalog should have a meal within 30 minutes. She indicated there was not a policy for the insulin administration, but the facility followed the manufacturer's guidance for the insulin. Further interview with the DON, indicated for a resident who had physician orders for a medication to be given with food, the medication should have been given with food.</p> <p>The MARS (Medication Administration Records) for Residents (#33, #218 and #237) who received Humalog insulin were provided by the DON on 1-8-2016 at 12:50 p.m. The MARS for each resident indicated the computerized checkmark for the Humalog administration was marked for the ordered time and not the administration time. An interview with the DON on 1-8-2016 at 3:00 p.m., indicated she was unable to obtain actual times of the insulin administration. The DON indicated the facility uses the protocol of</p>			

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F 0363 SS=E Bldg. 00	<p>an hour before and up to an hour after the ordered time to administer the medications, but for the insulin the nurse should give the insulin within the timeframe of getting their meals served.</p> <p>A review of the "Nursing 2016 Drug Handbook" (page 762) which was provided by the DON on 1-8-2016 at 2:05 p.m., indicated for Humalog to give "...subcutaneously within 15 minutes before...a meal...."</p> <p>3.1-25(b)(9)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, interview, and</p>	F 0363	The dietary staff were reeducated on the facility Portion Control	02/01/2016

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	<p>record review the facility failed to ensure a nutritionally adequate meal was provided during 2 of 4 meal observations potentially affecting 106 of 110 residents who received food prepared and served from the facility kitchens.</p> <p>Findings include:</p> <p>1. The menu for the lunch meal on 1/4/16 consisted of Spaghetti Noodles, Spaghetti Sauce with Meat, Italian Green Beans, Garlic Toast, Cranberry Chill, and beverage of choice.</p> <p>The Diet Spreadsheet for the lunch meal on 1/4/16 indicated a 4 ounce spoodle was to be used to served the Spaghetti Noodles.</p> <p>During an observation of the lunch meal in main facility kitchen on 1/4/16 at 12:00 p.m., Cook #1 was observed serving spaghetti noodles with a set of tongs instead of a 4 ounce spoodle.</p> <p>2. The menu for the lunch meal on 1/7/16 consisted of Unstuffed Peppers, Tossed Salad/Choice of Dressing, Buttered Breadstick, Black Forest Cake, and beverage of choice.</p> <p>The Diet Spreadsheet for the lunch meal on 1/7/16 indicated the serving size of the</p>		<p>Policy with emphasize given on ensuring they are using the appropriate measurement device for serving food. To ensure appropriate amounts of spaghetti noodles are provided for each patient, portion scales have been purchased. The diet spreadsheet has been revised to indicate ounces/amount for each portion to be served. The Culinary Service Manager and/or designee will complete random audits over all 3 meals to check that the proper measurement device for serving food is being used during meal service. Random audits will be done 3 times weekly for 2 weeks, weekly for 2 weeks, every 2 weeks for 8 weeks and monthly for 3 months with results discussed at monthly quality assurance meeting. Alleged date of compliance 2/1/2016.</p>	

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	<p>Tossed Salad as 1 cup.</p> <p>During an observation of the lunch meal in the Crown Dining Room kitchenette on 1/7/16 at 11:00 a.m., Cook #2 was observed to serve tossed salad from a stainless steel bowl into individual bowls with his gloved hands. He was not observed to use a 1 cup measurement.</p> <p>Cook #3 was interviewed on 1/8/16 at 10:05 a.m. During the interview, she indicated dietary staff were to reference the spread sheets for each meal to determine the serving size of each food and what serving utensils were to be used.</p> <p>A current facility policy "Portion Control", approved on March 2015 and provided by the Administrator on 1/8/16 at 2:00 p.m., indicated "...The menu should list the specific portion size for each food item. Menus should be posted at the tray line for staff to refer to for proper portioning of servings for each diet...The most dependable methods of use when measuring portions is to serve the food with ladles, scoops, spoodles, and spoons of standard sizes...."</p> <p>The 2011 Indiana Diet Manual indicated "...A diet should provide all the nutrients and energy in appropriate amounts for</p>			

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F 0371 SS=E Bldg. 00	<p>each person...A diet should be adequate at all times...Nutrition adequacy of diets must follow general standards and guidelines such as...The Dietary Reference Intakes...The U.S. Dietary Guidelines...."</p> <p>3.1-20(i)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review the facility failed to ensure staff washed their hands for the</p>	F 0371	The nursing staff and dietary staff were reeducated on the facility hand washing/hand hygiene policy. The dietary staff were	02/01/2016

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	<p>recommended amount of time, failed to wash their hands appropriately, and failed to wash their hands after touching soiled objects. The facility also failed to ensure staff handled food for the residents in a sanitary manner to prevent potential contamination and failed to ensure cold food was served at the proper temperature potentially affecting 106 of 110 residents who received food prepared by the facility kitchens.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 1/4/16 in the Royal Cafe Dining Room, the following was observed:</p> <p>At 12:24 p.m., Certified Nursing Assistant (CNA) #4 was observed to leave the dining table where she was assisting a resident to eat. She pushed a resident who was seated in her wheelchair back to the dining room table. She then was observed to lather her hands for 9 seconds prior to rinsing and returned to the dining room table to resume feeding the resident her meal.</p> <p>2. During an observation of the lunch meal on 1/5/16 in the Crown Dining Room, the following was observed:</p> <p>At 11:09 a.m., Dietary Aide #5 was</p>		<p>reeducated on the food temperature policy with emphasize on cold food temperatures and the need for cold foods to be placed in the cold food unit or on ice to maintain a safe temperature of 41 degrees or below throughout service. The Director of Nursing Services and/or designee and the Culinary Service Manager and/or designee will complete random audits over all 3 meals to ensure proper hand washing/hand hygiene is being followed by the nursing and dietary staff. The Culinary Service Manager and/or designee will do random audits over all 3 meals of cold food temperatures during meal service to ensure cold food temperatures remain at 41 degrees or below. Random audits will be done 3 times weekly for 2 weeks, then weekly for 2 weeks, every 2 weeks for 8 weeks and monthly for 3 months with results discussed at monthly quality assurance meeting. Alleged date of compliance 2/1/2016.</p>	

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	<p>observed to lather her hands for 13 seconds prior to rinsing. She was not observed to use a paper towel as a barrier when turning off the water faucet.</p> <p>At 11:15 a.m., Dietary Aide #5 was observed to lather her hands for 10 seconds prior to rinsing. She was not observed to use a paper towel as a barrier when turning off the water faucet.</p> <p>At 11:22 a.m., Dietary Aide #6 was observed to open a drawer and obtain a pair of disposable gloves. She donned the gloves without first washing her hands or performing hand hygiene. She then was observed to pick up a knife and fork of a resident seated at a dining room table to cut the ham slice into smaller pieces. The resident then used the utensils to eat.</p> <p>At 11:29 a.m., Dietary Aide #5 was observed to pull a pen out of her pocket to take the lunch order for a resident seated at a dining room table. She then was observed to open the cooler and pour beverages for the resident. She was observed to deliver the beverages to the resident, then pulled a pen out of her pocket to take lunch orders for 2 other residents seated at the same dining room table. Dietary Aide #5 delivered the orders to the service counter and served</p>			

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	<p>food to the residents without washing her hands or performing hand hygiene.</p> <p>At 11:34 a.m., Dietary Aide #5 was observed to pull a pen out of her pocket to take the lunch order for a resident. She was observed to open the cooler and pour beverages for the resident. She was then observed to serve the beverages to the resident and immediately went to another resident seated at a nearby dining room table. She was observed to touch the resident on her back, pull her pen out of her pocket to take her order for the lunch meal, prepare her beverages and served them to the resident, and place straws in the resident's glasses. She was not observed to wash her hands or perform hand hygiene after touching soiled objects.</p> <p>At 11:36 a.m., Dietary Aide #5 was observed standing at the service counter with her left hand in her pocket. She then was observed to serve food to a resident without washing her hands or performing hand hygiene.</p> <p>At 11:38 a.m., Dietary Aide #5 was observed to serve food to 3 other residents without washing her hands or performing hand hygiene.</p> <p>At 11:39 a.m., Dietary Aide #5 was</p>			

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	<p>observed to rub her eye with her right hand. She then was observed to refill a cup of coffee for a resident. She had not been observed to wash her hands since 11:15 a.m.</p> <p>At 11:41 a.m., Dietary Aide #5 was observed to lather her hands for 10 seconds prior to rinsing. She then was observed to put her thumbs into the pockets of her slacks, obtain a fork for a resident, and serve a food to a resident. She was not observed to wash her hands or perform hand hygiene.</p> <p>At 11:45 a.m., Dietary Aide #5 was observed to pull a pen out her pocket to take the lunch order for a resident. She then was observed to serve food to 2 residents without washing her hands or performing hand hygiene.</p> <p>3. During an observation of the lunch meal on 1/7/16 in the Crown Dining Room kitchenette, the following was observed:</p> <p>At 10:55 a.m., Cook #2 was observed to lather his hands for 10 seconds prior to rinsing. He then was observed to donn a pair of disposable gloves to take the temperature of the food. A large stainless steel bowl of tossed salad, with cheese, tomatoes, and mushrooms, was observed</p>			

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	<p>on the counter of the salad prep bar. The salad was not placed on ice. Cook #2 was not observed to take the temperature of the salad.</p> <p>At 11:00 a.m., Cook #2 was observed to lather his hands for 8 seconds prior to rinsing. He was not observed to use a paper towel as a barrier when turning off the water faucet. He immediately donned a pair of disposable gloves and placed the tossed salad from the stainless steel bowl into individual bowls with his gloved hands.</p> <p>At 11:02 a.m., Cook #2 accidentally spilled a plastic bin containing individual packets of jelly on the floor. He was observed to pick up the packets from the floor with his gloved hands. He was then observed to remove the disposable gloves, and lather his hands for 16 seconds prior to rinsing. He was not observed to use a paper towel as a barrier when turning off the water faucet. He immediately donned a pair of disposable gloves and started meal service.</p> <p>At 11:10 a.m., Cook #2 was observed to make a grilled cheese sandwich for a resident. When it was done, he carried the sandwich on a spatula over to a cutting board where he cut it in half. He then was observed to place the grilled</p>			

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	<p>cheese sandwich onto a plate for a resident with his gloved hands. He was not observed to place the sandwich on the plate by picking it up from the cutting board with the spatula.</p> <p>At 11:40 a.m., the stainless steel bowl of tossed salad remained on the counter of the salad prep bar, not on ice.</p> <p>4. During an observation of the lunch meal on 1/7/16 in the Royal Cafe dining room, the following was observed:</p> <p>At 12:12 p.m., CNA #7 was observed to push a dining room chair over to a dining room table with her bare hands. She then sat down next to a resident and began to feed her. She was not observed to wash her hands or perform hand hygiene after touching a soiled object.</p> <p>At 12:25 p.m., CNA #8 was observed to push a dining room chair over to a dining room table with her bare hands. She then sat down in-between two residents, picking up their utensils to assist them to eat. She was not observed to wash her hands or perform hand hygiene after touching a soiled object.</p> <p>The Administrator was interviewed on 1/8/16 at 1:20 p.m. During the interview she indicated staff were to lather their</p>			

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NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825
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	<p>hands for 20 seconds prior to rinsing and were to use a paper towel as a barrier to turn off the water faucet. She also indicated staff were to wash their hands or perform hand hygiene after touching their face, their clothing, a resident, or any soiled object. She further indicated staff were to wash their hands or perform hand hygiene prior to donning gloves and disposable gloves were to be treated the same as hands.</p> <p>5. An observation in the Crown Dining Room on 1-4-2016 indicated the following: At 11:19 a.m., Dietary Aide #6 was observed to lather her hands for 10 seconds prior to rinsing her hands. At 11:24 a.m., Dietary Aide #6 was observed to don gloves without washing her hands. She then picked up a knife and fork of a resident who was seated at the dining room table and cut up his noodles. Dietary Aide #6 returned the knife and fork to the resident's plate and the resident used the knife and fork to eat. After removing her gloves, Dietary Aide #6 was observed to lather her hands for 10 seconds prior to rinsing.</p> <p>A current facility policy "Handwashing/Hand Hygiene", approved on April 2014 and provided by the Administrator on 1/8/16 at 2:00 p.m.,</p>			

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	<p>indicated "...This facility considers hand hygiene the primary means to prevent the spread of infections...Employees must wash their hands...under the following conditions: Before and after direct resident contact...Before...handling food...Before and after assisting a resident with meals...After handling soiled equipment or utensils...After removing gloves or aprons...The use of gloves does not replace handwashing/hand hygiene...Vigorously lather hands with soap and rub them together, creating friction to all surfaces of at least twenty (20) seconds...turn off faucets with a clean, dry paper towel...."</p> <p>A current facility policy "Food Temperatures", approved on April 2014 and provided by the Administrator on 1/8/16 at 3:02 p.m., indicated "...All cold food items must be served to the resident at a temperature of 40 degrees F (Fahrenheit) or below at the time the resident receives the food...cold food items will be well below 41 degrees F when removed from cooling and must be kept below 40 degrees F until served to the residents...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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