STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155479	A. BUILDING 00 B. WING	08/26/2024

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KINGSTON CARE CENTER OF FORT WAYNE	1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 20, 21, 22, 23 & 26, 2024. Facility number: 000522 Provider number: 155749 AIM number: 100267040 Census Bed Type: SNF/NF: 73 SNF: 35 Total: 108 Census Payor Type: Medicaid: 64 Medicare: 9 Other: 35 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed Auguet 27, 2024	F 0000	This Plan of Correction is being prepared and executed because it is required by the provisions of state regulation, and not because Kingston Care Center of Fort Wayne agrees with the allegations and citations listed on the statement of deficiencies. Kingston Care Center of Fort Wayne 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 Care Center of Fort Wayne's written credible allegations of compliance. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Kingston Care Center of Fort Wayne reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction 9/6/2024, as the facility's credible allegation of compliance. We respectfully request paper compliance.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Holifield	HFA	09/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, interview, and record review the facility failed to ensure a dignified dining experience for 5 of 20 residents reviewed (Resident 49, Resident 76, Resident 77, Resident 82, and Resident 100). Findings include: During an observation on 8/21/24 at 12:46 PM, Resident 49, Resident 76 and Resident 82 were seated together at a table. Resident 49 and two unidentified residents had plates of food in front of them, but Resident 76 and Resident 82 had not yet been served. Cook 8 served trays to each table where other residents were waiting before taking lunch orders for Residents 76 and 82. Resident 76 and Resident 82 were served lunch at 1:18 pm. Resident 49 did not engage in eating tasks until her tablemates were served. Resident 49 indicated her food had become cold while she waited to eat. During an observation and interview on 8/21/24 at 1:19 PM, Resident 77 picked up plates, glasses and silverware from tables, placing them in a large dishpan on top of a cart. Resident 77 propelled herself by grabbing the tables where residents were seated while they were eating their lunch, and grabbed the handle on Resident 49's wheelchair, pulling the wheelchair forward. Resident 77 indicated she was trying to help the staff because they were running behind. She indicated she was concerned the room would not be cleared in time for the BINGO activity to start as scheduled at 2:00 PM. Resident 77 approached Resident 100 asking if she could clear his dishes from the table. Resident 100 had an irritated facial expression, shook his head, and indicated he did not understand what Resident 77 was trying to prove. Cook 8 spoke to Resident 100 and	F 0550	It is the policy of Kingston Care Center of Fort Wayne to ensure that residents have the right to a dignified existence. The facility will ensure that Residents are served together at each dining table prior to serving the next table within reason and appropriate accommodation to facilitate the dining experience. Residents dining in the dining room will receive their trays together with exceptions to be considered based on medical need or personal preference to joining a table already served. This includes resident identified as potentially affected as those that dine in the dining room. Dietary department staff have received re-education related to this policy as titled, “SNF Serving of Meal Trays” starting 9/3/24 and in an ongoing progressive manner. The dietary director will assure that the process of delivering meal trays is considerate to this regard in not only education but in active steps taken. Education also includes nursing staff, administrative staff, and activities staff who all may facilitate this process. The Culinary Services Manager/Designee will monitor compliance by observing meal services. The Culinary Services Manager/Designee will complete a Quality Assurance Audit of meal service delivery 3 times per week	09/06/2024

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	indicated Resident 77 was just trying to help. Resident 77 approached Resident 49, Resident 76 and Resident 82 and began taking their plates and silverware without asking. Resident 76 and Resident 82 had not had time to complete eating their desserts. In an interview on 8/21/24 at 1:24 PM, Dietary Aide 7 indicated residents should be served table by table. If residents arrive late, they should be worked in as soon as possible, before beginning service to an unserved table. In an interview on 8/21/24 at 1:27 PM, Cook 8 indicated trays are served on a first come, first serve basis. In an interview on 8/22/24 at 10:25 AM, the Director of Nursing indicated residents at a table should be served at the same time. She indicated any late arriving residents should be worked in as soon as possible rather than serving in order of arrival. In an interview on 8/23/24 at 9:21 AM, Resident 76 indicated she had bussed tables in the dining room to help the staff before. She indicated no training or oversight was provided. In the same interview, Resident 82 indicated residents bussing table in the dining room was not an unusual occurrence. She indicated residents frequently help when short staffing occurs. 1) Resident 49's record was reviewed on 8/23/24 at 1:01 PM. Diagnoses included major depressive disorder, unspecified dementia, moderate, with other behavioral disturbance, and generalized anxiety disorder. Resident 49's current quarterly, Minimum Data Set		for 8 weeks, 2 times per week for 8 weeks, and then 1 time per week for 2 months. Any abnormal findings will be addressed at the time and re-education will be conducted. The Culinary Services Manager/Designee will report all findings to the Administrator and to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter for one quarter.	

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	(MDS) dated 7/30/24 indicated their Basic Interview for Mental Status (BIMS) score was 8 (cognitively impaired). 2) Resident 76's record was reviewed on 8/23/24 at 1:40 PM. Diagnoses included major depressive disorder recurrent severe without psychotic features, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and dysphagia following cerebral infarction. Resident 76's current quarterly MDS dated 7/29/24 indicated indicated her Basic Interview for Mental Status score not available due to not being assessed. Resident 76's quarterly MDS dated 6/18/24 indicated her BIMS score was 15 (cognitively intact). 3)Resident 77's record was reviewed on 8/23/24 at 10:15 AM. Diagnoses included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, unspecified psychosis not due to a substance or known psychological condition, and generalized anxiety disorder. Resident 77's current quarterly MDS dated 7/9/24 indicated her BIMS score was 15 (cognitively intact). 4) Resident 82's record was reviewed on 8/23/24 at 12:36 PM. Diagnoses included chronic kidney disease, stage 3, unspecified, generalized anxiety disorder, and essential hypertension. Resident 82's current quarterly MDS dated 7/2/24 indicated her BIMS score was 15 (cognitively intact). 5) Resident 100's record was reviewed on 8/23/24			

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	at 12:42 PM. Diagnoses included unspecified fracture of shaft of right femur, subsequent encounter for closed fracture with routine healing, displaced fracture of body of scapula left shoulder, subsequent encounter for fracture with routine healing, multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing. Resident 100's current Admission MDS dated 7/3/24 indicated his BIMS score was 14 (cognitively intact). A current policy titled SNF Meal Service and Distribution provided by the Administrator on 8/22/24 at 2:30 PM indicated meals should be distributed to residents promptly and the dining room should be cleaned after each meal. The policy did not indicate each meal should be served table by table. 3.1-3(a)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part			

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	489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review the facility failed to ensure formulation of an advanced directive after admission for 1 of 1 residents reviewed. (Resident 30) Findings include: Resident 30's record was reviewed on 8/21/24 at 9:40 AM. Diagnoses included respiratory failure, Parkinson's disease, and type 2 diabetes with chronic kidney disease.	F 0578	It is the policy of Kingston Care Center of Fort Wayne to ensure that residents' retain the right for formulate an advanced directive. Resident #30 has been reviewed by DON/Designee on 8/27/24 to ensure an advanced directive was established. Current residents admitting to the facility have been reviewed by the DON/Designee on 8/27/24 to ensure orders/care plans are in	09/06/2024

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	A review of Resident 30's current quarterly Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). A review of Resident 30's current care plan, dated 8/14/24, titled Resident and family have chosen a DNR order, indicated Resident 30 would not have life-saving measures performed, and all caregivers would be informed of code status. A review of physician orders dated 8/21/24 at 11:00 AM indicated Resident 30's DNR order was discontinued 8/14/24, and not reinstated until 8/21/24. A review of progress notes dated 8/20/24 indicated Resident 30 declined to decide an advanced directive status upon readmission from hospital on 8/19/24. In an interview on 8/21/24 at 10:30 AM, the Administrator indicated code status should be found in physician orders and care plan. If code status is not there then the resident would be assumed to be full code. In an interview on 8/21/24 at 12:45 PM, the DON (Director of Nursing) indicated the resident came back from the hospital on 8/19/24 and was unsure what code status he wanted. Advance Directive documents presented at 12:45 PM indicated Resident 30's code status was updated to DNR on 8/21/24 at 12:00 PM. A current policy dated 8/21/24 provided by the DON indicated the facility would determine whether the resident had executed advanced directives, and whether the resident would like a DNR order issued while in the facility.		place with regard to the right to formulate and designate an advanced directive. Licensed Nurses were educated by the staff development nurse on policy titled, “Advanced Directives” starting 9/3/24 and as an ongoing and progressive education plan. The DON/Designee will monitor compliance by reviewing new admissions orders and care plans to support advanced directive formulation. The DON/Designee will complete a Quality Assurance Audit for all advanced directive documentation 3 times per week for 8 weeks, 2 time per week for 8 weeks, and then weekly for 2 months. Any abnormal findings will be addressed at the time and re-education will be conducted. The DON/Designee will report all findings to the Administrator and the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter.	

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	3.1-4(d)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.			

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	(ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on interview, and record review the facility failed to ensure all Minimum Data Set (MDS) sections were completed for 2 of 32 residents reviewed (Resident 76, and Resident 66). Findings include: 1) Resident 76's record was reviewed on 8/23/24 at 1:40 PM. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, recurrent severe without psychotic features, and prediabetes. Resident 76's current quarterly MDS dated 7/29/24 indicated their Basic Interview for Mental Status (BIMS) score was not completed. Each question in the BIMS assessment was answered "not assessed". In an interview on 8/26/24 at 8:30 AM, the Director	F 0640	It is the policy of Kingston Care Center of Fort Wayne to ensure that there is sufficient and appropriate coding and transmission of resident assessments. Current residents with MDS assessments are reviewed during and at the point of the ARD for accuracy and completion of BIMs assessments. The therapy department was re-educated by Director of Rehab on the policy, “MDS Completion Guidelines” 9/5/24. The Director of Rehab/Designee will monitor compliance by reviewing BIMs are completed appropriately and according to policy. The Director of Rehab/Designee will complete a	09/06/2024

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	of Therapy indicated the therapy department was responsible for the completion of the MDS section C for all MDS assessments for all residents. He indicated a problem with completion was identified and the department heads began reviewing MDS assessments in the morning meeting each day around two weeks ago. In an interview on 8/26/24 at 8:45 AM, the MDS Coordinator 6 indicated he was aware of several occurrences of Section C of the MDS not being completed or not be completed timely. He indicated this had been an issue for several months. He indicated the MDS department should receive completed MDS sections from all departments by the end of the business day on the Assessment Reference Date.2) Resident 66's record was reviewed on 8/20/24 at 11:04AM. Resident 66 was admitted on 7/26/24. An admission MDS dated 8/2/24 did not have a BIMS score assessment. completed. In an interview on 8/21/24 at 1:35 PM, Resident 66 indicated he was able to carry on a conversation. Resident 66 was giving fact-based responses and was showing use of reasoning skills. Resident 66 recalled information given at the beginning of interview with ease and was able to explain and demonstrate his answers appropriately. A Performance Improvement Plan (PIP) from the facility regarding comprehensive assessment and timing provided by the MDS coordinator on 8/26/24 at 9:17AM, indicated the facility had a meeting on 5/16/24, 6/14/24, and 8/9/24. The target end date for the PIP was 8/17/2024. The last activity documented an intervention was discussed on 8/23/24, however, the intervention was not listed.		Quality Assurance Audit for BIMs documentation with regard to MDS ARDs 3 times per week for 8 weeks, 2 times per week for 8 weeks, and then monthly for 2 months. Any abnormal findings will be addressed at the time and re-education will be conducted. The Director of Rehab /Designee will report all findings to the Administrator and to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter.	

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	TheResident Assessment Instrument (RAI) manual dated October 2023 indicated the following: CMS's RAI Version 3.0 Manual CH 3: MDS Items [C] Page C-1 SECTION C: COGNITIVE PATTERNS Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions. A current policy titled MDS Completion Guidelines dated 8/26/24 provided by MDS Coordinator 6 on 8/26/24 at 9:17 AM did not provide guidelines for completion of each MDS section. An undated document titled MDS Parts, provided by MDS Coordinator 6 on 8/26/24 at 9:17 AM indicated the therapy department was responsible for completing BIMS scoring for the MDS completion. A policy and procedure titled "MDS Completion Guidelines" dated April 2014, indicated ...1. MDS Nurses are to complete every MDS within seven (7) days of the assessment date			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on interview and record review the facility	F 0699	It is the policy of Kingston Care	09/06/2024

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	failed to identify and initiate plans to mitigate trauma informed care for 1 of 1 resident reviewed. (Resident 66) Resident 66's record review began on 8/20/24 at 11:04AM. Diagnoses included heart disease, depression, and Post Traumatic Stress Disorder (PTSD). Resident 66's Trauma Screening Questionnaire dated 7/30/24, was not completed on admission. Resident 66 did not have a plan of care in place to minimize or alleviate triggers, no PTSD related triggers were identified. Resident 66 had a care plan related to alteration in amount of sleep secondary to insomnia. The insomnia was not identified as a sign or symptom of his PTSD. There were no progress notes to indicate family had collaborated to assist in identifying PTSD triggers. Prior to admission, Resident 66 lived at home with his wife. There were no progress notes to indicate counseling or talk therapy had been attempted. Resident 66's admission Minimum Data Set (MDS) dated 8/2/24 was not fully completed. Section C for BIMS (Brief Interview of Mental Status) indicated the resident had not been completely assessed. The assessment did not include assessment through staff interview. Section D for mood was not completed. Section I for Diagnosis did indicate depression nor PTSD. In an interview, on 08/21/24 at 01:35PM, Resident 66 talked about his time in the Vietnam war. He discussed his ongoing sickness from "agent orange". He stated, "my hands are useless, so am		Center of Fort Wayne to ensure that trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice, accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Resident #66 has been reviewed by Director of Social Services/Designee on 8/22/23 to the resident has sufficient supports, identification of triggers, and care planning with regard to preferences of this topic. Current residents reviewed for any trauma related dxs. with no other like resident's identified on 9/3/24, with lookback through the first date following survey. Social Services team was educated by the Social Services Director on the policy titled, "Trauma-Informed Care" on 9/4/24. The Social Services Director/Designee will monitor compliance by reviewing Trauma screens for new admissions. The Social Services Director/Designee will complete a Quality Assurance Audit for trauma informed screens and dxs. documentation 3 times per week for 4 weeks, 2 times per week for 12 weeks, and then weekly for 2 months. Any abnormal findings will be addressed at the time and re-education will be conducted.	

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	155479	A. BUILDING 00 B. WING	08/26/2024

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	I". Resident 66 was crying yet easily consoled. Resident 66 expressed feelings of gratitude of the time spent with him. He indicated his wife would visit twice a week. Other than her visits, no one attempted to understand him. In an interview, on 8/21/24 at 2:18PM Social Services Director (SSD) 5 indicated she did not understand why Resident 66's BIMS score was not completed. She indicated therapy was responsible for Section C of MDS. She explained Resident 66 only triggered for sleep disturbance on the trauma assessment. She further explained the team felt by talking to Resident 66 further they may upset him, so they only care planned him for sleep disturbance. SSD 5 was unable to identify Resident 66's PTSD triggers. SSD 5 was unable to identify why the mood section D was not completed because SSD 5 was responsible for Section D. In an interview, on 08/22/24 at 10:26 AM, the Director of Nursing (DON) indicated Resident 66 would not talk to us about it. The management team had discussed the resident in behavior meeting on 8/22/24 and discussed a referral to the psychologist since he wasn't comfotable discussing the PTSD with staff. Resident 66 would not tell the facility what his PTSD triggers were. She indicated Resident 66 should have been care planned for the PTSD diagnosis and watched for any signs of triggers. The DON indicated she was unsure if the family had been contacted regarding the PTSD or any triggers they may have been aware of. A policy titled, Trauma-Informed Care, dated October 2022 was received 8/22/24 at 12:16PM by SSD 5. The policy indicated ...trauma informed care in accordance with professional standards of		The Social Services Director/Designee will report all findings to the Administrator and to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter.	

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	practice and accounting for residents' preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. To determine if the resident is currently experiencing trauma or is at risk the Trauma Screening Questioner will be completed on all resident at the time of admission and as needed during the stay. 1) Ensure that appropriate staff is trained to provide support to residents with a trauma related diagnosis...2) Trauma Screening will be completed by LSW (Licensed Social Worker) upon admission...3) The LSW to provide support and care plan interventions upon admission and throughout resident stay and educate other staff as needed			
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review the facility failed to ensure pureed food was prepared to guideline specifications. 5 of 5 residents requiring pureed diets consumed food prepared by the dietary staff. (Resident 5, Resident 10, Resident 27, Resident 39, and Resident 68). In an observation followed by an interview, on 8/20/24 at 11:16AM, Cook 8 identified a pan of meat with charred spots, and sticking to wax paper as pork tenderloin. Cook 8 took 8 varied size pieces of the meat and put into the grinder adding 3 soup ladles of gravy. Cook 8 was shaking the grinder and then using a spatula to wipe the sides.	F 0805	It is the policy of Kingston Care Center of Fort Wayne to ensure that food is provided in a form that meets individuals' needs. Production recipes have been reviewed and assured available for preparation of pureed foods. This includes production recipes as they relate to current residents with pureed food consistency ordered. Cooks were re-educated by Culinary Services Manager on the policy titled, "Use of Recipes" on 9/4/2024. The Culinary Services	09/06/2024

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	Cook 8 added 1 additional ladle of gravy. There was no recipe visible. Cook 8 indicated she was unable to determine the measurement of soup ladle. Cook 8 asked Cook 7 if there was a recipe for the pork tenderloin puree. Cook 7 located the recipe book. The book did not include the recipe for tenderloin puree. The kitchen manager was surprised the recipe did not include puree. He indicated he would locate a recipe and bring it for review along with a policy later in the day. On 8/20/24 at 1:16PM, the Administrator provided the production recipe for pork tenderloin roasted pureed thick. Yield was 20 portions. Cook 8 was yielding 6 so she would have cut this and done 1/3. The recipe called for 3lbs and 12 ounces of roasted pork tenderloin, 1 1/3 cup beef base , 1 quart hot water, and ½ cup food thickener. Cook 8 used 8 breaded pork tenderloin patties (no weight was measured on the patties). The patties were not similar in style to the pork tenderloin being served to other residents. In lieu of hot water, beef base and thickener, Cook 8 used gravy. The gravy was not measured, and she did not use thickener, so the consistency of the puree was not uniform. 1) Resident 5's record was reviewed, on 8/20/24 at 9:16AM, diagnoses included respiratory disease, heart disease, dementia, and dysphagia. Resident 5 had an order for pureed/dysphagia thin consistency, dated 12/6/23. 2) Resident 10's record was reviewed, on 8/20/24 at 9:21AM, diagnoses included heart disease, lung diseases, dementia, and dysphagia. Resident 10's diet order was pureed/dysphagia, thin consistency, dated 12/30/23. 3) Resident 27's record was reviewed, on 8/23/24 at 9:26AM, diagnoses included stroke, diabetes,		Manager/Designee will monitor compliance by observing the production and use of recipes. The Culinary Services Manager/Designee will complete a Quality Assurance Audit for pureed meal preparation 3 times per week for 8 weeks, 2 times per week for 8 weeks, and then weekly for 2 months. Any abnormal findings will be addressed at the time and re-education will be conducted. The Culinary Services Manager/Designee will report all findings to the Administrator and to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter.	

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	heart disease, dementia, and dysphagia. Resident 27's was ordered blenderized texture thin consistency, dated 6/8/23. 4) Resident 39's record was reviewed, on 8/23/24 at 9:52AM, diagnoses included Alzheimer's, adult failure to thrive, and dysphagia. Resident 39's diet order was blenderized texture, nectar thick consistency, dated 12/17/22. 5) Resident 68's record was reviewed, on 8/23/24 at 9:58AM, diagnoses included malnutrition, heart disease, dementia, and dysphagia. Resident 68 had an order pureed/dysphagia thin consistency diet, dated 10/30/23. A policy and procedure titled, "Use of Recipes", dated April 2014 was received from the Administrator on 8/22/24 at 12:16PM. The policy indicated recipes were to be used when preparing menu items. 3.1-21(a)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review the facility failed to ensure a sanitary environment for dining in the crown dining room. 20 residents of 108 residents residing in the facility consumed meals in the crown dining room. Findings include: During an observation and interview on 8/21/24 at 1:19 PM, Resident 77 picked up plates, glasses and silverware from tables, placing them in a large dishpan on top of a cart. No gloves were worn, and no hand hygiene was observed. A white fluffy substance was observed on Resident 77's hand, consistent in appearance to the mashed potatoes served at the lunch meal. Resident 77 propelled herself by grabbing the tables where residents were seated. She grabbed the handle on Resident 49's wheelchair and pulled her wheelchair forward. Resident 77's hands still contained remnants of white fluffy residue. She had not utilized had hygiene. Cook 8 indicated Resident 77 liked to help, but she was not capable of maintaining sanitation standards. Cook 8	F 0880	It is the policy of Kingston Care Center of Fort Wayne to ensure that residents provided a sanitary environment with regard to the dining experience. The facility will ensure that proper hand hygiene is utilized with table clearing of resident plates, cups, and silverware, etc. The process of clearing tables throughout and following mealtimes will include proper sanitation standards. This includes residents identified as potentially affected as those that dine in the dining room. Dietary department staff have received re-education related to this policy as titled, “SNF Serving of Meal Trays” as well as, “Policies and Practices—Infection Control.” The dietary director will assure that the process of removing meal trays, or items, is	09/06/2024

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	indicated she had difficulty stopping Resident 77 from bussing the tables because she was busy serving other residents and she was the only employee in the dining room. In an interview on 8/23/24 at 9:21 AM, Resident 76 indicated she had bussed tables in the dining room to help the staff before. She indicated no training or oversight was provided. In the same interview, Resident 82 indicated residents bussing tables in the dining room was not an unusual occurrence. She indicated residents frequently help when short staffing occurs. She indicated no training about hand washong had been provided. 1) Resident 49's record was reviewed on 8/23/24 at 1:01 PM. Diagnoses included major depressive disorder, unspecified dementia, moderate, with other behavioral disturbance, and generalized anxiety disorder. Resident 49's current quarterly, Minimum Data Set (MDS) dated 7/30/24 indicated their Basic Interview for Mental Status (BIMS) score was 8 (cognitively impaired) 2) Resident 76's record was reviewed on 8/23/24 at 1:40 PM. Diagnoses included major depressive disorder recurrent severe without psychotic features, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and dysphagia following cerebral infarction. Resident 76's current quarterly MDS dated 7/29/24 indicated her indicated her Basic Interview for Mental Status score not available due to not being assessed. Resident 76's quarterly MDS dated 6/18/24 indicated her BIMS score was 15 (cognitively intact)		considerate to this regard in not only education but in active steps taken. Education also includes nursing staff, administrative staff, and activities staff who all may facilitate this process. The Culinary Services Manager/Designee will monitor compliance by observing meal cleanup, or clearing of tables. The Culinary Services Manager/Designee will complete a Quality Assurance Audit of meal cleanup, or clearing of tables, 3 times per week for 8 weeks, 2 times per week for 4 weeks, and then 1 time per week for 4 months. Any abnormal findings will be addressed at the time and re-education will be conducted. The Culinary Services Manager/Designee will report all findings to the Administrator and to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter for one quarter.	

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	3) Resident 77's record was reviewed on 8/23/24 at 10:15 AM. Diagnoses included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, unspecified psychosis not due to a substance or known psychological condition, and generalized anxiety disorder. Resident 77's current quarterly Minimum Data Set (MDS) dated 7/9/24 indicated her Basic Interview for Mental Status) BIMS score was 15 (cognitively intact). Resident 77's current care plan titled ...displays manipulative behavior ...indicated the resident had a problem of needing diversional activities, with a goal date of 10/22/24. Interventions included removing Resident 77 from the public area when behavior was disruptive and providing a diversional activity. Resident 77's current care plan titled ...choices are important ...indicated Resident 77 wanted to do therapeutic work, such as collecting dirty dishes with a goal date of 10/22/24. Interventions included educating the resident and family on infection control policy. 4) Resident 82's record was reviewed on 8/23/24 at 12:36 PM. Diagnoses included chronic kidney disease, stage 3, unspecified, generalized anxiety disorder, and essential hypertension. Resident 82's current quarterly MDS dated 7/2/24 indicated her BIMS score was 15 (cognitively intact). In an interview on 8/22/24 at 10:25 AM, the Director of Nursing (DON) indicated education on hand hygiene, instructions to not interfere with			

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	others while they eat and sanitation principles for Resident 77 was not available for review. The DON indicated she could not recall when her appropriateness to perform bussing activities was last reviewed. A current policy titled Policies and Practices - Infection Control dated August 2019 provided by the Administrator on 8/20/24 at 10:30 AM indicated the facility's policies and procedures are intending to facilitate maintaining a safe, sanitary and comfortable environment to help prevent and manage transmission of diseased and infections. The policy indicated infection control policies and practices apply equally to all personnel, residents and visitors. The policy indicated training should occur when indicated. The policy indicated having an objective of maintaining a safe, sanitary and comfortable environment. 3.1-18(a)			