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	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 the Investigation of Complaints IN00444040 and IN00444543. Complaint IN00444040 - No deficiencies related to the allegations are cited. Complaint IN00444543 - Federal/State deficiencies related to the allegations are cited at F842. Survey dates: October 18 and 21, 2024 Facility number: 000522 Provider number: 155479 AIM number: 100267040 Census Bed Type: SNF/NF: 76 SNF: 32 Total: 108 Census Payor Type: Medicare: 21 Medicaid: 67 Other: 20 Total: 108 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 22, 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 11/1/2024, as the facility's credible allegation of compliance. We respectfully request paper compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Based on interview and record review, the facility failed to ensure complete and accurate medical records were maintained for 1 of 3 residents reviewed (Resident D). Findings include: On 10/18/24 at 2:21 P.M., Resident D's spouse was interviewed. During the interview, she indicated several concerns with the care provided the resident during his stay. She alleged Resident D's medication to treat his bi-polar disorder was decreased and a new medication given. She had spoken with the Nurse Practitioner (NP) and indicated she had not wanted the residents medication to be decreased and had not wanted him to be placed on a new medication. Additionally, she alleged the staff hadn't noticed the resident had no teeth or dentures and had not served him soft foods. She indicated the resident was given food he was unable to chew so he just hadn't eaten. On 10/18/24 at 3:07 P.M., Resident D's record was reviewed. Diagnoses included bradycardia (slow heart rate), chronic obstructive pulmonary disease (COPD), chronic kidney disease, diabetes, dementia and bi-polar disorder. 1. A physician order, dated 9/13/24, was written for Lithium Carbonate (used to treat bi-polar disorder) 300 milligrams (mg) extended release (ER) by mouth, 2 times per day to treat bi-polar disorder. On 9/18/24 at 8:47 a.m., the Psychiatric NP visited with the resident. The resident had recently been sent to the hospital from his assisted living (AL) apartment. The NP had been providing services to the resident for the past 3 years. During the visit,	F 0842	It is the practice of Kingston Care Center of Fort Wayne to ensure that resident medical records are maintained to assure accuracy and completeness. This includes documenting within the progress notes, plans for care, and orders which are maintained. The resident identified through survey no longer resides at this facility to address any area which may be of concern, or for any further audit of medical records for updates. Current Resident Records will be audited in an ongoing manner for all residents' related to lab, medication orders, and physician orders to assure compliance and ongoing updates are made as appropriate.Care plans reviewed for any edentulous residents along with diet orders to assure appropriate. Nursing staff have received re-education on the policy of change in status and communication with regard as well as job description with performance standards. Therapy staff have received re-education on physician's orders and with job description and performance standards. Ongoing re-education will be provided through the facility Nurse Educator for all new hires as well. The Director of nursing/designee will ensure that the process order review, notifications and documentation in place related to resident change in	11/01/2024

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	the resident was observed to be weak and confused and it took him a few minutes to recall who the NP was. He had intermittent tremors in both of his arms. He was to continue his current dose of Lithium 300 mg ER by mouth 2 times per day. -At 2:39 p.m., the Medical NP visited the resident to review his lab results obtained on 9/17/24. There were no new orders. A Lab Results Report, collected on 9/20 and reported on 9/21/24, indicated the residents blood lithium level was elevated at 1.6 (normal 1.0-1.2 mmol/L). There was no physician order documented to indicate the residents blood lithium level was to be drawn and there were no nurse notes documented on 9/20/24 to indicate labs had been drawn from the resident. There were no nurse notes, documented on 9/21/24, to indicate the doctor or NP had been notified of the abnormal lab results. On 9/23/24 at 11:04 a.m., the medical NP visited the resident for his increased tremors and review of lab results. Tremors in both arms/hands had increased over the past week interfering with his ability to help care for himself. Lab results from 9/20/24 were reviewed. His lithium level was elevated at 1.6. His dosage of Lithium ER 300 mg, 2 times per day would be decreased to 1 time per day for 4 days, then resume 2 times daily dosing. His lithium level would be rechecked on 9/26/24. If his tremors worsened, she would prescribe Amantadine (antiviral medicine used to treat tremors) 100 mg by mouth daily. On 9/24/24 at 9:32 a.m., the medical NP documented she had spoken with the resident's wife the night before (9/23/24) by phone. His wife indicated the resident had taken Lithium for years		condition. Education also includes nursing staff, rehabilitation staff who all may facilitate this process. The Director of Rahab/Designee will monitor compliance of ST eval and tx. orders including orders related to swallow studies. The Director of Rehab/Designee will complete a Quality Assurance Audit to assure presence of ST eval. and tx. orders, 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, with compliance achieved. 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 for one quarter. The Director of Nursing/Designee will monitor compliance by reviewing to ensure physician and lab orders are written and abnormal results have been called to the provider. The Director of Nursing/Designee will complete a Quality Assurance Audit of documentation, notification and appropriate order entry 3 times per week 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	

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	due to his drastic mood changes when not taking the medication regularly and she hadn't wanted his dosage changed. The NP reordered the resident's Lithium ER 300 mg woul back to 2 times per day and his blood lithium level rechecked on 9/26/24. If his tremors worsened, he could be given Amantadine 100 mg by mouth daily. A physician order, dated 9/24/24 at 9:06 a.m., was to give Lithium ER 300 mg by mouth 2 times per day. -At 8:00 p.m., Lithium ER 300 mg by mouth 2 times per day was discontinued by the psychiatric NP and decreased to Lithium (immediate release) 150 mg by mouth 2 times per day. There was no nursing documentation to indicate the reason for or the change in the Lithium orders. On 10/21/24 at 10:57 A.M., the psychiatric NP was interviewed. She indicated she had received a secure message from the medical NP indicating the concern with the residents increased tremors and elevated blood lithium level. She had reviewed the secure message, the evening of 9/24/24, had responded back to the facility, and decreased Resident D's lithium dosage. On 10/21/24 at 11:36 P.M., the Director of Nursing (DON) was interviewed. She indicated it was a company policy to allow the use of secured messaging between healthcare professionals providing care to residents at the facility but facility nursing staff were expected to document new order changes in the residents record. 2. A Nursing Admission/Observation form, dated 9/13/24 at 1:18 p.m., indicated an observation of Resident D's oral (mouth/teeth/gums) status was completed. The observation indicated there were		time and re-education will be conducted. The Director of Nursing/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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	no issues observed. The resident was prescribed a no concentrated sweet diet (NCS) (low carbohydrate due to diabetes) which was regular texture with thin liquids. There was no documentation Resident D was endentulous (without teeth) A Speech Therapy Evaluation and Plan of Treatment, dated 9/17/24, indicated the resident had been referred to speech therapy to assess the residents cognition and safety awareness. A swallow study was suggested due to the resident indicating he had difficulty taking multiple pills at once, needed his food cut into smaller pieces, and had difficulty chewing and swallowing food like lettuce. A consultation, evaluation, and management report for dysphasia (difficulty swallowing), dated 9/17/24, indicated the resident was being evaluated due to coughing when swallowing and feeding/swallowing difficulties. The evaluation was done to determine the safest diet for the resident. On visual inspection of the residents mouth, he was observed with no teeth. He indicated his dentures no longer fit well so he didn't wear them. There were no physician orders documented for a speech therapy evaluation or a swallow study to be completed due to chewing and swallowing difficulties. Resident care plans hadn't indicated the resident was edentulous (lacking teeth) and required meals with soft foods. In an interview, on 10/21/24 at 2:54 PM, the DON indicated there was not a policy regarding documentation.			

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	A policy regarding complte and accurate documentation was not available for review by time of exit. This Citation relates to Complaint IN00444543. 3.1-50(a)(1) 3.1-50(a)(2)			