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	02/09/2023

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 IN00400348 and IN00401079. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00400348 - Substantiated. Federal/state deficiencies related to the allegations are cited at F692 Complaint IN00401079 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684 and F760. Survey dates: February 8 and 9, 2023 Facility number: 000522 Provider number: 155479 AIM number: 100267040 Census Bed Type: SNF/NF: 72 SNF: 34 Total: 106 Census Payor Type: Medicare: 28 Medicaid: 53 Other: 25 Total: 106 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 13, 2023	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. 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 02/23/23, as the facility's credible allegation of compliance.	
F 0684 SS=D	483.25 Quality of Care			

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

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to assess and monitor the resident following a significant medication error for 1 of 3 residents reviewed (Resident D). Findings include: On 2/8/23 at 10:15 A.M., Resident D's record was reviewed. Diagnoses included insulin dependent diabetes, dementia, pressure ulcers, and peripheral vascular disease. The resident was receiving hospice services for end-of-life care and pain management. A physician order, dated 8/13/22, for Morphine Sulfate (Concentrate) Solution 20 milligrams per 1 milliliter (20 mg/ml); indicated to give 5 milligrams (mg) by mouth every 2 hours as needed for pain (0.25 ml). The order was discontinued on 1/11/23 and new orders given for Morphine Sulfate 20 mg/ml-give 0.5 ml (10 mg) every 2 hours as needed for pain and Morphine Sulfate 20 mg/ml-give 0.5 ml every 6 hours (routine). A review of the Medication Administration Record (MAR) indicated to give Morphine Sulfate 20 mg/5 ml-give 5 ml by mouth every 2 hours as needed and Morphine Sulphate 20 mg/5 ml-give 5 ml by mouth every 6 hours (routine).	F 0684	It is the policy of Kingston Care Center of Fort Wayne to Assess and monitor all residents following a significant medication error. Nurse identified error for Resident D, and assessed resident condition and responsible parties, DON, Admin, Primary Care and Hospice Providers were made aware of error and resident condition. This was a facility reported incident to Indiana Department of Health. No other residents were noted to have had significant medication errors in the facility. The DON/Designee reviewed all residents on 1/12/23. All nurses were educated on Order Entry, 5 rights Medication Administration, and the updated process for 2 nurses for new verbal Hospice orders, and with Morphine to be administered in milligrams not milliliters, and this was completed by 1/13/23. All nurses received additional education by DON/Designee on 2/21/23, regarding Medication Error Policy, Medication Error	02/23/2023

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	A Controlled Substance Accountability Sheet for Morphine Sulfate 20 mg/ml: take (0.25 ml) (5 mg) by mouth every 2 hours as needed for pain, indicated Morphine Sulfate 0.25 ml had been signed out and administered as ordered, between the dates of 11/11/22 and 1/4/23. On 1/11/23 at 4:45 p.m., Morphine Sulfate 5 ml (milliliters) (100 mg) was signed out and administered to the resident. Progress notes indicated the following: -1/12/23 at 12:00 a.m., 2 nurses identified a medication error for the resident. The resident was assessed and responsible parties notified. The hospice nurse came in to assess the resident, the medication order was clarified and corrected with the hospice nurse. A verbal order was received to hold the 10:00 p.m. dose on 1/11/23 and reassess in the morning before administering the 5:00 a.m. dose on 1/12/23. -1/12/23 at 11:02 a.m., indicated the resident's son has been notified the resident had been given an incorrect Morphine dose the previous evening and now had a change in his condition prompting need for a dose of Narcan (medication used to treat opioid overdose). The resident had been assessed with a respiratory rate of 4 per minute (normal 16-20 breaths per minute) with periods of apnea (no breaths). He was started on oxygen at 4 liters per nasal cannula. There was no indication in the note a physician had been notified of the resident's low respiratory rate. -1/12/23 at 1:05 p.m., a respiratory note indicated the resident had an observed change in condition. The respiratory therapist (RT) had been asked by nursing to assess the resident. Upon assessment, his respirations were at 8 breaths per minute and his oxygen saturation was at 80% (normal oxygen		Checklist including notification, assessments and monitoring. All Licensed Nurses will follow the Medication Error Checklist anytime a medication error is identified. The DON/Designee will monitor compliance by reviewing all medication errors that are identified to ensure assessment and monitoring has been completed as ordered. The DON/Designee will complete a Quality Assurance Audit for all medication error documentation 3 times per week for 4 weeks, 1 time per week for 4 weeks, and then monthly for 4 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. The Administrator will report all findings to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter	

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	saturation-greater than 90%). The resident was placed on 4 liters of oxygen via nasal cannula, his oxygen saturations increased to 93-96% and his heart rate was 117 beats per minute (normal-60-100 beats per minute). -1/12/23 at 1:17 p.m., the note indicated the resident had been unresponsive "due to morphine overdose". His blood pressure (BP) was low at 80/40, pulse (P) elevated at 112, respirations (R) were 10 per minute and oxygen saturation was at 99% on oxygen at 4 liters per nasal cannula. At 10:46 a.m., the NP (Nurse Practitioner) was notified and order given to administer Narcan 0.4 mg/ml per intramuscular injection. This was administered into the left deltoid. At 10:50 a.m., the resident started responding and talking. His BP was 116/67, P: 107, and R: 15. At 12:07 p.m., the resident was unresponsive with a BP of 95/62, P: 106, R: 7 and oxygen saturation at 91%. The NP was notified and an order received for Narcan 0.4/0.1 ml nasal spray. This was administered at 12:17 p.m. At 12:25 p.m., the resident started to respond and talk. His BP was 113/68, P: 106, R: 15, and oxygen saturation was 94%. At 1:00 p.m., the resident was able to consume 240 ml of orange juice. There were no documented assessments, vital signs taken, or monitoring of the resident for signs and symptoms due to morphine overdose after the medication error on 1/11/23 at 4:45 p.m. was identified on 1/12/23 at 12 a.m. until the morning of 1/12/23 when the respiratory therapist performed an assessment due to the resident's change in condition. In an interview on 2/8/23 at 2:47 P.M., the facility pharmacist indicated 100 mg of Morphine given to the resident would've caused lethargy, slowed			

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	respiratory rate, clammy skin, slurred speech, blurry vision and potentially, respiratory arrest. On 2/8/23 at 3:25 P.M., the RT was interviewed. She indicated on the morning of 1/12/23, she'd arrived to the facility between 6-6:30 a.m. A night nurse told her that the resident had been given a high dose of morphine and wasn't responding. The RT went to Resident D's room to assess him, observed he was unconscious and non-responsive. His respirations were shallow at 8 breaths per minute and his oxygen saturation on room air was 80%. She administered oxygen at 4 liters per minute per nasal cannula. She reported her concerns with the resident's change in condition to the oncoming shift nurses and the management team which included the Director of Nursing Services. On 2/8/23 at 4:00 P.M., the Administrator was interviewed. She indicated she was notified the evening of 1/11/23 when the medication error had been identified and staff had been instructed to monitor and document the resident's condition. A policy regarding medication errors and assessment was not available for review. This Federal tag relates to Complaint IN00401079.			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to provide a therapeutic diet for 1 of 3 residents reviewed with therapeutic diets (Resident E). Findings include: On 2/8/23 at 10:05 A.M., Resident E's record was reviewed. Diagnoses included diabetes, hypertensive heart disease, and pressure ulcers. An admission MDS (Minimum Data Set) assessment, dated 12/19/22, indicated the resident had no cognitive impairment and no moods or behaviors. A care plan, dated 12/12/22, indicated the resident had the potential for alteration in nutrition, risk for weight changes/fluctuations, and required a no added salt, no concentrated sweet diet (NAS/NCS). Interventions included: give diet per order NAS/NCS, monitor oral intakes, and record meal intakes daily. On 2/8/23 at 11:09 A.M., Resident E was interviewed. He indicated he was not always	F 0692	It is the policy of Kingston Care Center of Fort Wayne to offer a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet. The surveyor identified Resident E, who potentially did not receive a food tray No other residents were found to have been affected during the survey. Resident E was interviewed, and food preferences were reviewed. The care plan was updated. All Nursing and Dietary staff will be educated on 2/22/23 on Recording Percent of Meal Consumed Policy. Dietary Staff will check off a resident listing, to ensure a tray has been created and sent to every resident for each meal. The Dietary Staff will collect the meal tickets upon return to the kitchen and ensure documentation of meal consumption has been completed.	02/23/2023

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	served his ordered diet/meals. He indicated a grievance had been filed with the facility but had not been resolved. A review of grievances indicated the resident had filed a grivance about not receiving meals. Review of his meal intakes indicated there were no meal intakes documented for breakfast or lunch on 1/13/23, no supper intake on 1/14/23, no breakfast documented on 1/15/23, and there were no meal intakes documented for 1/16/23. On 2/9/23 at 12:51 P.M., the Administrator indicated residents were provided diets as ordered per the physician and meal intakes were to be documented. If meal intakes were not documented, it would indicate a meal had not been provided. A current facility policy, titled "Recording Percent of Meal Consumed", was provided by the Administrator on 2/9/23 which stated: "Staff will document the percentage of each meal consumed for a resident...." This Federal tag relates to IN00400348. 3.1-46		Dietary Manager will monitor compliance 5 times per week by reviewing the census forms and printing the missing documentation report for meal consumptions. Any findings will be addressed at the time and re-education will be conducted. The Dietary Manager will also follow-up with the resident. Administrator/Designee will complete a Quality Assurance Audit to ensure Dietary compliance with meal delivery and documentation 5 times per week for 4 weeks, 3 times per week for 4 weeks, and then weekly for 4 months. Any abnormal findings will be addressed at the time and re-education will be conducted. The Administrator/Designee will report all findings to the QA Committee and will be reviewed at the QA Monthly Meeting for 3 months and quarterly thereafter	
F 0760 SS=J Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed were free from a significant medication error. The error resulted in respiratory distress, need for emergent treatment and the potential for death (Resident D).	F 0760	It is the policy of Kingston Care Center of Fort Wayne to ensure that residents are free from a significant medication error. Kingston Care Center of Fort	02/09/2023

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	The Immediate Jeopardy began on 1/11/23 when Resident D was administered 100 milligrams of Morphine by mouth, 20 times the amount of medication prescribed. The facility failed to assess and monitor the resident for side effects after identifying the medication error. This resulted in respiratory distress and need for emergent treatment. The Administrator was notified of the Immediate Jeopardy on February 8, 2023 at 4:09 P.M. The Immediate Jeopardy was removed, and the deficient practice corrected, on 1/27/23 when the facility implemented a systemic plan that included all nurses were in-serviced on safe medication administration, an initial audit of physician's orders for morphine sulfate, and completed medication administration competencies with nursing staff. The correction date was prior to the start of the survey and was therefore past noncompliance. Findings include: On 2/8/23 at 10:15 A.M., Resident D's record was reviewed. Diagnoses included insulin dependent diabetes, dementia, pressure ulcers, and peripheral vascular disease. The resident was receiving hospice services for end-of-life care and pain management. A physician order, dated 8/13/22, for Morphine Sulfate (Concentrate) Solution 20 milligrams per 1 milliliter (20 mg/ml); indicated to give 5 milligrams (mg) by mouth every 2 hours as needed for pain (0.25 ml). The order was discontinued on 1/11/23, a new order for Morphine Sulfate 20 mg/ml-give 0.5 ml (10 mg) every 2 hours as needed for pain and Morphine Sulfate 20 mg/ml-give 0.5 ml every 6 hours (routine) was written.		Wayne respectfully requests an Informal Dispute Resolution with regards to the cited deficiency F760 s/s "J" which was cited following the above referenced survey. The Statement of Deficiencies ("2567") further alleges that this resulted in immediate Jeopardy, which began on January 11, 2023 when the medication was administered and was removed on "February 9, 2023, when the facility inserviced nurses on safe medication administration". The facility disputes that a condition of Immediate Jeopardy persisted for twenty-eight (28) days following medication error. The Immediate Jeopardy removal plan provided during the survey demonstrates that the condition of Immediate Jeoardy was removed on 1/13/23, and that audits and competencies were completed to verify compliance with the training, demonstrating full compliance with the requirement prior to the start of the survey. Therefore, we seek IDR and ask that the citation be revised accordingly. On 1/11/23, Resident D, a hospice patient, had order changes in Morphine doses, related to expected decline and end of life transition phase. On 1/11/23, at approximately 10:55 pm it was communicated that Resident D, had received 100 mg of morphine instead of 5 mg, at 5:00 pm	

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	A review of the Medication Administration Record (MAR) indicated to give Morphine Sulfate 20 mg/5 ml-give 5 ml by mouth every 2 hours as needed and Morphine Sulphate 20 mg/5 ml-give 5 ml by mouth every 6 hours (routine). A Controlled Substance Accountability Sheet for Morphine Sulfate 20 mg/ml: take (0.25 ml) (5 mg) by mouth every 2 hours as needed for pain, indicated Morphine Sulfate 0.25 ml had been signed out and administered as ordered, between the dates of 11/11/22 and 1/4/23. On 1/11/23 at 4:45 p.m., Morphine Sulfate 5 ml (milliliters) was signed out and administered to the resident. This would equal a dose of 100 mg, 20 times the dose prescribed. The MAR dated January 2023 indicated the resident received 100 mg of Morphine on 1/11/23 at 5 p.m. Progress notes indicated the following: -1/12/23 at 12:00 a.m., 2 nurses identified a medication error for the resident. The resident was assessed and responsible parties notified. The hospice nurse came in to assess the resident, the medication order was clarified and corrected with the hospice nurse. A verbal order was received to hold the 10:00 p.m. dose on 1/11/23 and reassess in the morning before administering the 5:00 a.m. dose on 1/12/23. -1/12/23 at 11:02 a.m., indicated the resident's son had been notified the resident had been given an incorrect Morphine dose the previous evening and now had a change in his condition prompting need for a dose of Narcan (medication used to treat opioid overdose). The resident had been assessed with a respiratory rate of 4 per minute		administration. Nurse identified error for Resident D, and assessed resident condition and responsible parties, DON, Admin, Primary Care and Hospice Providers were made aware of error and resident condition. This was a facility reported incident to Indiana Department of Health. In-house Respiratory Therapist continued to monitor Resident D, since Morphine is known to slow respiratory status. On 1/12/23, resident was administered Narcan X2 per primary care orders, due to decreased responsiveness and respirations, with resident having positive response to Narcan administration, as ordered. Investigation into med discrepancy was identified to be due to order for 5mg/1Ml=5 milligrams, and the bottle in cart having higher dosage concentrate of 20mg/1 milliliter. The order was corrected, and all doses were moved to milligrams instead of milliliters to ensure this did not recur. No other residents were affected by this deficient practice. All residents with Morphine orders were reviewed by the DON/Designee on 1/12/23 to ensure accuracy of doses being administered. In addition, the following actions were taken to prevent a reoccurrence. · Agency Nurse was immediately placed off work and	

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	(normal 16-20 breaths per minute) with periods of apnea (no breaths). He was started on oxygen at 4 liters per nasal cannula. There was no indication in the note a physician had been notified of the resident's low respiratory rate. -1/12/23 at 1:05 p.m., a respiratory note indicated the resident had an observed change in condition. The respiratory therapist (RT) had been asked by nursing to assess the resident. Upon assessment, his respirations were at 8 breaths per minute and his oxygen saturation was at 80% (normal oxygen saturation-greater than 90%). The resident was placed on 4 liters of oxygen via nasal cannula, his oxygen saturations increased to 93-96% and his heart rate was 117 beats per minute (normal-60-100 beats per minute). -1/12/23 at 1:17 p.m., the note indicated the resident had been unresponsive "due to morphine overdose". His blood pressure (BP) was low at 80/40, pulse (P) elevated at 112, respirations (R) were 10 per minute and oxygen saturation was at 99% on oxygen at 4 liters per nasal cannula. At 10:46 a.m., the NP (Nurse Practitioner) was notified and order given to administer Narcan 0.4 mg/ml per intramuscular injection. This was administered into the left deltoid. At 10:50 a.m., the resident started responding and talking. His BP was 116/67, P: 107, and R: 15. At 12:07 p.m., the resident was unresponsive with a BP of 95/62, P: 106, R: 7 and oxygen saturation at 91%. The NP was notified and an order received for Narcan 0.4/0.1 ml nasal spray. This was administered at 12:17 p.m. At 12:25 p.m., the resident started to respond and talk. His BP was 113/68, P: 106, R: 15, and oxygen saturation was 94%. At 1:00 p.m., the resident was able to consume 240 ml of orange juice.		on a do not return to facility. The agency was made aware of the nurse's error. · A meeting was held with Hospice Care team and facility IDT, and procedure implemented to prevent a reoccurrence, which includes 2 Nurses to confirm all verbal orders received by Hospice. · Morphine dosages reviewed and changed to ensure all dosages were in milligrams vs milliliters to prevent a reoccurrence, completed 1/12/23 by DON/Designee. · All nurses were educated on Order Entry, 5 rights Medication Administration, and updated process for 2 nurses for new verbal Hospice orders, and with Morphine to be administered in milligrams not milliliters, and this was completed by 1/13/23. · Med Pass competencies were also initiated on 1/13/23 for ongoing compliance check. · Agency Binders education/resources provided for each agency staff. · House Audit of all Morphine orders completed by DON on 1/12/23 to ensure no discrepancies. DON/designee audited all identified residents with morphine orders, and to ensure ongoing compliance, Morphine orders will be reviewed three times per week for four weeks, weekly for eight weeks, and monthly for 3 months	

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	In an interview on 2/8/23 at 2:47 P.M., the facility pharmacist indicated 100 mg of Morphine given to the resident would've caused lethargy, slowed respiratory rate, clammy skin, slurred speech, blurry vision and potentially, respiratory arrest. On 2/8/23 at 3:25 P.M., the RT was interviewed. She indicated on the morning of 1/12/23, she'd arrived at the facility between 6-6:30 a.m. A night nurse told her the resident had been given a high dose of morphine and wasn't responding. The RT went to Resident D's room to assess him, observed that he was unconscious and non-responsive. His respirations were shallow at 8 breaths per minute and his oxygen saturation on room air was 80%. She administered oxygen at 4 liters per minute per nasal cannula. She reported her concerns with the resident's change in condition to the oncoming shift nurses and the management team which included the Director of Nursing Services. On 2/8/23 at 4:00 P.M., the Administrator was interviewed. She indicated she was notified the evening of 1/11/23 when the medication error had been identified and staff had been instructed to monitor and document the resident's condition. A current facility policy, provided by the Administrator on 2/9/23 at 1:00 P.M., and titled "Administering Medications", stated the following: "Medications shall be administered in a safe and timely manner, as prescribed...3. Medications must be administered in accordance with the orders...7. The individual administering the medication shall check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication...."		by DON/designee. DON/designee will provide ongoing education to any nurses if identified to be non-compliant. Any discrepancies will be reported to the QAPI committee and additional education provided as identified per, individual, basis. QAPI committee to review audits for pattern/trend and continue recommendations for ongoing improvement Date this deficiency was corrected 1/13/23	

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	02/09/2023

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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	The past noncompliance Immediate Jeopardy began on 1/11/23. The Immediate Jeopardy was removed, and the deficient practice corrected, on 1/27/23 when the facility implemented a systemic plan that included all nurses were in-serviced on safe medication administration, an initial audit of physician's orders for morphine sulfate, and completed medication administration competencies with nursing staff. The correction date was prior to the start of the survey and was therefore past noncompliance This Federal tag relates to Complaint IN00401079. 3.1-48(c)(2)			