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	04/16/2024

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 IN00431135, IN00431174 and IN00431781. Complaint IN00431135 - No deficiencies related to the allegations are cited. Complaint IN00431174 - No deficiencies related to the allegations are cited. Complaint IN00431781 - Federal/State deficiencies related to the allegations are cited at F697. Survey dates: April 15 and 16, 2024 Facility number: 000522 Provider number: 155479 AIM number: 100267040 Census Bed Type: SNF/NF: 77 SNF: 36 Total: 113 Census Payor Type: Medicare: 29 Medicaid: 68 Other: 16 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 17, 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 04/30/2024, as the facility's credible allegation of compliance. We respectfully request paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Holifield	HFA	04/30/2024

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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F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure pain management for 1 of 3 residents experiencing pain reviewed (Resident Q). Findings include: On 4/15/24 at 10:16 A.M., Resident Q was interviewed. She'd had a recent stay at the facility for rehabilitation services following a fracture due to a fall. During her stay, she experienced unrelieved pain. This led to her early discharge from the facility. She indicated she believed her pain worsened during her stay becasue she sat in a chair and on the toilet for long periods of time. This increased the pain in her hip and pelvis. Additionally, she alleged pain medications were not given timely and when administered, were ineffective in relieving the pain. She indicated she had entered the facility on 3/21/24, asked for prescribed pain medication but wasn't given anything until 3:30 a.m. on 3/22/24. She indicated this put her behind with pain management making it difficult to regain control of the pain. She initiated early discharge due to ineffective pain management. On 4/16/24 at 11:44 A.M., Resident Q's record was reviewed. Diagnoses included a fractured pelvis from a fall and required skilled therapy services. She had a diagnosis of chronic pain syndrome	F 0697	It is the policy and practice of Kingston Care Center of Fort Wayne to provide residents with professional standard of practice regarding pain management as defined in subpart §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Facility corrective actions for any resident(s) that may have potentially been affected include record review and interview of any potential like residents with immediate correction as applicable. Resident who proposed complaint is no longer residing within the facility to address individually. Facility also completed interviews of other like residents that may have had potential to be affected with immediate corrective actions taken as applicable. Nursing	04/30/2024

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	and was prescribed an anti-seizure medication used for chronic pain but was not on any routine opioid medications. A 5 day Medicare MDS (Minimum Data Set) assessment, dated 3/26/24, indicated the resident was cognitively intact. She was admitted for a short stay to complete therapy prior to returning to her home. There was no pain assessment completed on the MDS. A care plan, dated 3/21/24, indicated the resident had pain due to a fall. Interventions included: provide pain medications as ordered; monitor and record pain characteristics; monitor response to pain prevention/interventions; evaluate the effectiveness of pain interventions and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results and impact on functional ability; and attempt non-pharmacological interventions for pain management as indicated/appropriate (distraction, repositioning, massage, cryotherapy, etc). A hospital note, dated 3/19/24 at 9:37 a.m., indicated the resident had been receiving Hydrocodone-Acetaminophen 5-325 mg (milligram) 2 tablets by mouth every 4 hours as needed for pain. A physician order, dated 3/20/24 (day prior to admission) was for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every 8 hours as needed for pain. A MAR (Medication Administration Record) dated March 2024, indicated the resident had not received pain medication on 3/21/24. Hydrocodone-Acetaminophen 5-325 mg was administered on the following dates and times:		education provided by DON on 4/23/24. Nursing records review conducted by DON completed to identify like residents, interviews will be conducted on like residents identified in record review by nurse management team on 4/25/24. Therapy education provided by Administrator and Director of Rehab on 4/23/24. Therapy records review with audit was also conducted by Director of Rehab and completed on 4/25/24. Measures put into place to ensure systemic changes included re-education of nursing employees regarding facility policies with respect to pain management, SOM PP F697, and PCC re-education r/t documentation. Facility also provided education of therapy employees regarding facility policies with respect to pain management, SOM PP F697. Employees will receive ongoing re-education along with the auditing process of this plan of correction. DON, or designee, will audit by interviewing 5 like residents of random selection for any reported concerns regarding pain management plans. This audit will be completed weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for 2 months. Any discrepancies will be reported to	

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	-3/22/24: 3:41 a.m., 12 noon, and 8:17 p.m. There was no further pain medication administered until the following morning. The record didn't indicate any non-pharmacological interventions had been offered to the resident. -3/23/24: 7:27 a.m. and 3:26 p.m. There was no further pain medication administered until the following morning. The record didn't indicate any non-pharmacological interventions had been offered to the resident. -3/24/24: 2:58 a.m. and 11:51 a.m. for a pain level of 10 out of 10 (worst pain ever), and 8:37 p.m. for continued pain at a level 8 out of 10. The record didn't indicate any non-pharmacological interventions had been offered to the resident. -3/25/24: 4:42 a.m. for pain level of 6 out of 10, and 12:57 p.m. for continued pain level at 6. There was no further pain medication administered until the following morning. The record hadn't indicated if or what non-pharmacological interventions had been offered to the resident. -3/26/24: 2:02 a.m. for pain level of 5, and 11:06 a.m. for continued pain level of 7. The record didn't indicate any non-pharmacological interventions had been offered to the resident. A Physical Therapy- PT evaluation and Plan of Treatment form, dated 3/22/24 at 10:54 a.m., indicated the resident complained of pain at rest at a level 10 out of 10. The pain was in her left hip and was "sharp". She indicated her pain level with movement was 5 out of 10. The pain was in her left hip and felt "sharp". The pain limited the resident's activities. The pain was relieved with		the QAPI committee and additional education provided as identified on an individual basis. QAPI committee to review audits for pattern/trend and continue recommendations for ongoing improvement. DON, or designee, will audit by reviewing 5 charts for any documentation concerns with regard to pain management to assure documented pain complaints have sufficient and timely action plans. This audit will be completed weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for 2 months. Any discrepancies will be reported to the QAPI committee and additional education provided as identified on an individual basis. QAPI committee to review audits for pattern/trend and continue recommendations for ongoing improvement. Director of Rehab, or designee, will audit by reviewing 10 charts for any therapist documentation concerns with regard to pain management to assure documented pain complaints have sufficient and timely action plans and/or communication documented with nursing team. This audit will be completed weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for 2 months. Any	

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	rest and pain medications but worsened with prolonged sitting, standing, or inactivity. Physical Therapy encounter notes indicated: -3/22/24 at 2:36 p.m., indicated the resident had been sitting up in her wheelchair and complained of left hip pain from sitting too long. The resident was provided with an ice bag to use on the left hip to alleviate pain. -3/23/24 at 3:24 p.m., indicated the resident reported she had received her pain medication later than she was supposed to and had sharper pain in her hip, in the morning, as a result. Occupational Therapy-OT evaluation and Plan of Treatment form, dated 3/22/24 at 2:10 p.m., indicated the resident was provided with a different wheelchair to decrease discomfort. She was offered ice to decrease pain but declined at the time. The nurse reported the resident had not yet been due for her pain pill while in session. She reported pain at rest and with movement, was a 7 out of 10, constant, "throbbing", and located in her left pelvis. Her pain was relieved with pain medications. Occupational Therapy encounter notes indicated: -3/22/24 at 2:45 p.m., the resident complained of left pelvic pain. The nurse indicated the resident wasn't due for pain medications yet. The resident was offered ice which she declined. She was provided with a smaller wheelchair with a cushion becaue the wheelchair was too large for her and the cushion added additional pain relief. -3/25/24 at 3:09 p.m., indicated the therapist was notified the resident was discharging the		discrepancies will be reported to the QAPI committee and additional education provided as identified on an individual basis. QAPI committee to review audits for pattern/trend and continue recommendations for ongoing improvement. We respectfully request paper compliance.	

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	following day. During the session, she reported pain in her left groin 6 out of 10 and indicated she had been overdue for her pain medications. The nurse administered them during the OT session. A nurse progress note, dated 3/24/24 at 3:46 p.m., indicated the NP (Nurse Practitioner) was notified of difficulty controlling the resident's pain with pain medication only given every 8 hours as needed. The NP replied she would address it in the morning because she had not yet met the resident. A physician progress note, dated 3/25/24 at 1:34 p.m., indicated the resident had been seen for a 2nd day follow up to her hospitalization. The note indicated the resident wanted to discharge as soon as possible. There was no documentation about the resident's pain and difficulty controlling with her current pain medications. There were no changes made to the plan of care to address timing of medications in relation to therapy, limitations set to limit her time up in a wheelchair, possible changes in pain medication, or additional pain medications added (such as Tylenol or topical pain medication). No new non-pharmacological interventions had been added to the care plan On 4/16/24 at 2:30 P.M., the Director of Nursing was interviewed. She indicated staff were to develop and implement a comprehensive pain management plan for residents experiencing pain, including use of non-pharmacological interventions in addition to pain medications. Pain medications were to be administered per physician orders. She indicated the facility did not use a comprehensive pain assessment form.			

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	On 4/16/24 at 1:20 P.M., a current copy of the facility policy, titled "Pain Assessment and Management" provided by the Administrator, indicated: "3. Pain management is a multidisciplinary care process that includes the following: Assessing the potential for pain; effectively recognizing the presence of pain; identifying characteristics of pain; addressing the underlying causes of the pain; developing and implementing approaches to pain; identifying and using specific strategies for different levels and sources of pain; monitoring effectiveness of interventions; and modifying approaches as necessary. Conduct a comprehensive pain assessment upon admission to the facility...and when there is onset of new or worsening pain...Assessing pain: 1. During the comprehensive pain assessment gather the following information...a. history of pain and it's treatment including pharmacological and non-pharmacological interventions; b. characteristics of pain: intensity, description of pain, pattern of pain, location and radiation of pain, frequency/timing/duration of pain...d. factors that precipitate or exacerbate pain. e. factors and strategies that reduce pain...Defining goals and appropriate interventions...Implementing pain management strategies: non-pharmacological interventions may be appropriate alone or in conjunction with medications...Monitoring and modifying approaches...Documentation: 1. Document the resident's reported level of pain with adequate detail...." This tag relates to Complaint IN00431781. 3.1-37(a)			