STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155479	B. WING 12/22/2023			/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
KINGGT		OF FORT WAYNE	1010 W WASHINGTON CENTER RD				
KINGSTO	JN CARE CENTER	OF FORT WAYNE		FORT WAYNE, IN 46825			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
F 0000							
Bldg. 00							
3	This visit was for th	e Investigation of Complaint	F 0	000	This Plan of Correction is bein	ıa	
	IN00422127.			300	prepared and executed because it		
	11.00.22127.				is required by the provisions of		
	Complaint IN00422	2127 - Federal/state deficiencies			state regulation, and not beca		
	•	tions are cited at F692 and			Kingston Care Center of Fort	430	
	F812.	none are cited at 1 0/2 and			Wayne agrees with the allegate	tions	
	1012.				and citations listed on the	.iUIIO	
	Survey date: Decem	nber 22, 2023			statement of deficiencies.		
	Survey date. Decem	1001 22, 2023.					
	Facility number: 00	0522			Kingston Care Center of Fort	aad	
	Provider number: 13				Wayne maintains that the alle	-	
				deficiencies do not individually or			
	AIM number: 10020	6/040		collectively jeopardize the health			
	C DIT				and safety of the residents, no		
	Census Bed Type:				are they of such character as	iO	
	SNF: 41				limit our capacity to render		
	SNF/NF: 69				adequate care as prescribed by	-	
	Total: 110				regulation. This plan of correc		
					shall operate as Kingston Car		
	Census Payor Type:	:			Center of Fort Wayne's writter		
	Medicare: 26				credible allegations of complia	nce.	
	Medicaid: 63				This plan of correction is not		
	Other: 21				meant to establish any standa	rd of	
	Total: 110				care contract, obligation or		
					position, and Kingston Care		
		reflect State Findings cited in			Center of Fort Wayne reserve		
	accordance with 410	0 IAC 16.2-3.1.			possible contentions and defe		
					in any civil or criminal actions	or	
	Quality review com	pleted December 22, 2023			proceeding.		
					Please accept the date of		
					correction 01/17/2024, as the		
					facility's credible allegation of		
					compliance. We respectfully		
					request paper compliance.		
F 0692	483.25(g)(1)-(3)						
SS=E	_	n Status Maintenance					
Bldg. 00	§483.25(g) Assiste	ed nutrition and hydration.					
	1		1		i		I .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Pamela Grabbe RN-DON 01/09/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155479	B. W	ING		12/22	/2023
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			WASHINGTON CENTER RD		
KINGSTON CARE CENTER OF FORT WAYNE					WAYNE, IN 46825		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		astric and gastrostomy					
		taneous endoscopic					
		percutaneous endoscopic					
	1	enteral fluids). Based on a hensive assessment, the					
	•	re that a resident-					
	lacility mast crisa	To that a resident-					
	§483.25(g)(1) Ma	intains acceptable					
	,,,	tritional status, such as					
	usual body weigh	t or desirable body weight					
	range and electrolyte balance, unless the resident's clinical condition demonstrates						
	that this is not possible or resident						
	preferences indic	ate otherwise;					
	§483.25(g)(2) Is offered sufficient fluid intake						
	to maintain prope	r hydration and health;					
	§483.25(g)(3) Is offered a therapeutic diet						
		utritional problem and the					
	health care provid	der orders a therapeutic diet.					
	Based on interview	Based on interview and record review the facility		692	It is the policy and practice of Kingston Care Center of Fort		01/12/2024
		al consumption percentage was			Wayne to maintain nutrition a	ınd	
		of 4 residents reviewed			hydration status for residents		
	(Resident B, Resid	ent D, Resident E and Resident			residing in the facility.		
	F).				Residents B, D E and F review	wed	
					for adverse outcomes related	to	
	Findings include:				missing meal consumption documentation. No adverse		
	A record review was completed for Resident B				outcomes identified.		
		33 PM. Resident B's point of care			All residents residing in facility	/	
	charting, dated 11/22/23 - 12/20/23 indicated meal				that receive meals from dietar		
	1	ntage was not documented for			department have the potential	-	
	the following dates	_			be effected by deficient		
					practice.Facility conducted au		
		or supper documentation			of meal consumption records		
	11/24/23: no suppe				other residents that receive m		
		fast or supper documentation			from dietary services. No adve	erse	
	12/1/23: no supper	documentation			outcomes noted to deficient		

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	00	COMPLETED		
		155479	B. W				/2023	
				_			-	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
				1010 W WASHINGTON CENTER RD				
KINGSTO	ON CARE CENTER	R OF FORT WAYNE		FORT WAYNE, IN 46825				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	11E	DATE	
	12/2/23: no supper documentation				practice.			
	12/3/23: no breakfa	ast documentation; lunch			Measures put into place to er	sure		
	documentation indi	icated resident was not			systemic changes included			
	available				re-education of staff regardin	g		
	12/4/23: no lunch o	or supper documentation			facility policies with respect to	_		
		ast or supper documentation			recording of meal intakes by			
	12/6/23: no supper				development nurse on 12/27/			
	12/8/23: no supper				Employees will receive ongoing			
	12/12/23: no suppe				education and will be able to	5		
	12/15/23: no suppe				demonstrate understanding o	f		
	12/16/23: no suppe	er documentation			policy elements.			
	•				DON, or designee, will audit b	ΟV		
	Resident B's progress notes, dated 11/22/23 -				record review, 10 residents of	-		
	12/20/23, were rev	iewed. There was no			random selection—for			
	documentation reg	arding meal consumption or			documentation of meal			
	_	lent was not available for meals.			consumption. This audit will b	е		
					completed weekly for 8 weeks			
	2. A record review	was completed for Resident D			then bi-weekly for 8 weeks, th			
	on 12/21/23 at 12:3	30 PM. Resident D's point of			monthly for 2 months. Any			
	care charting, dated	d 11/22/23 - 12/20/23, indicated			discrepancies will be reported	l to		
	meal consumption	percentage were not			the QAPI committee and			
	documented for the	e following dates and meals:			additional education provided	as		
					identified on an individual bas	is.		
	11/24/23: no suppe	er documentation			QAPI committee to review au	dits		
	12/1/23: no supper				for pattern/trend and continue	:		
	12/3/23: no lunch d	locumentation			recommendations for ongoing	j		
	12/4/23: no supper	documentation			improvement.			
	12/7/23: no breakfa	ast documentation						
	12/8/23: no supper	documentation			We respectfully request pape	r		
	12/9/23: no supper	documentation			compliance.			
	12/10/23: no suppe	er documentation			Date of Completion: 1/12/202	24		
	12/12/23: lunch documentation indicated resident							
	was not available							
	12/15/23: no lunch documentation							
	12/18/23: no breakfast documentation 12/19/23: no breakfast documentation							
	Resident D's progre	ess notes, dated 11/22/23 -						
	12/20/23, were rev	iewed. There was no						
	documentation regarding meal consumption or							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155479		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G 00	COMI	E SURVEY PLETED 2/2023	
NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE			101	EET ADDRESS, CITY, STATE, 10 W WASHINGTON CE RT WAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ent was not available for meals.	ID PREFI TAG	CROSS-REFERENCED TO	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
	3. A record review on 12/21/23 at 12:3 charting, dated 11/2	was competed for Resident E 7 PM. Resident E's point of care 22/23 - 12/20/23, indicated meal attage was not documented for				
	12/3/23: no lunch d 12/4/23: no breakfa 12/6/23: no lunch d 12/7/23: no breakfa 12/8/23: no supper 12/9/23: no supper 12/10/23: no supper 12/13/23: no lunch 12/14/23: no breakf 12/15/23: no lunch 12/19/23: no breakf	r documentation cast or lunch documentation ocumentation st or supper documentation ocumentation st or lunch documentation documentation documentation r documentation documentation cast documentation documentation cast documentation cast documentation				
	12/20/23, were revi documentation rega indication the reside 4. A record review on 12/21/23 at 12:2 charting, dated 11/2	ewed. There was no arding meal consumption or ent was not available for meals. was completed for Resident F 7 PM. Resident F's point of care t2/23 - 12/20/23, indicated meal artage was not documented for and meals:				
		ocumentation documentation ast or lunch documentation ast or lunch documentation				

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		X1) PROVIDER/SUPPLIER/CLIA	î ´	CONSTRUCTION 00	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED				
		155479	B. WING		12/22/2023			
NAME OF P	PROVIDER OR SUPPLIER	. }		T ADDRESS, CITY, STATE, ZIP COD	-			
				1010 W WASHINGTON CENTER RD				
KINGSTO	ON CARE CENTER	OF FORT WAYNE	FORT WAYNE, IN 46825					
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	RIATE			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
		fast or supper documentation;						
	was not available	nentation indicated resident						
	12/18/23: no supper	r documentation						
	12/19/23: no supper							
	12/17/23. 110 orcaki	ast documentation						
	Resident F's progre	ss notes, dated 11/22/23 -						
	12/20/23, were revi	ewed. There was no						
		ording meal consumption or						
	indication the reside	ent was not available for meals.						
	During on interview	y on 12/21/23 of 12:03 DM						
	During an interview on 12/21/23 at 12:03 PM, Registered Nurse (RN) 2 indicated when a resident							
		eir room the Certified Nursing						
		nented the resident's meal						
		ntage. RN 2 indicated when a						
		eal in the dining room, the						
		ented the resident's meal						
	consumption percer							
	-	v on 12/21/23 at 1:05 PM, CNA						
		umented meal consumption						
		esidents who ate their meals in						
		ndicated when the resident ate						
	-	the dietary staff documented						
	the resident's meal	consumption percentage.						
	During an interview	on 12/21/23 at 1:18 PM, the						
	_	eated the CNA documented						
		percentage for the residents						
	who ate their meals							
	Administrator indic	ated the dietary staff						
	documented meal c	onsumption percentage for the						
	residents who ate th	neir meal in the dining room.						
	The Admininstrator	also indicated the department						
	heads monitored the	e documentation.						
	A assumant1: 1	stad Index 2010 4:41-4						
		ated July 2018, titled						
	-	of Meal Consumed," was						
	provided by the Administrator on 12/21/23 at 1:59		1		l			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED A. D. WING A. D. W			
		155479	B. WING	_	12/22/2023
NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE		1010	T ADDRESS, CITY, STATE, ZIP COD W WASHINGTON CENTER RD WAYNE, IN 46825		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION icated staff documented meal	TAG	DEFICIENCY)	DATE
	consumption percer				
	This citation relates	to Complaint IN00422127.			
	3.1-46(1)				
F 0812 SS=E	483.60(i)(1)(2) Food				
Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.			
	approved or consifederal, state or logical (i) This may include directly from local applicable State a regulations. (ii) This provision of facilities from using gardens, subject that applicable safe graphical (iii) This provision.	le food items obtained producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility			
	serve food in according standards for food Based on observation review the facility for procedures were followed.	ore, prepare, distribute and ordance with professional service safety. on, interview and record ailed to ensure sanitation lowed. 108 of 110 residents cility ate their meals prepared	F 0812	It is the policy and practice of Kingston Care Center of Fort Wayne to provide Food procurement, store/prepare a serve in a sanitary manner All residents residing in facility that receive meals from dietar	nd
	Findings include:			department have the potentia	-

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PRINTED: 01/10/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155479	B. WING		12/22/2023	
	PROVIDER OR SUPPLIER		1010 V	ADDRESS, CITY, STATE, ZIP COD W WASHINGTON CENTER RD WAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1. During an observe there were 4 pots/ps with moisture visib. In an interview on indicated there should dishes. During a continuous 10:56 AM-10:58 A plate covers from the covers then placed. The plate covers were observed removing stacked the cups on observed to still be the tray of cups and transport to another. In an interview on 12 aide 5 indicated the aide 5 indicated it was serve in the other distribution of the covers and transport to use. Dietary dishes should not be dishes and plate covers and plates and plate covers and plates and plates on indicated the plates.	ration on 12/21/23 at 9:23 AM, an and 3 baking dishes stacked le in between the dishes. 12/21/23 at 9:23 AM, Cook 4 aldn't be moisture between 12/21/23 at 9:23 AM, Cook 4 aldn't be moisture between 12/21/23 at M, Dietary Aide 7 removed the dishwasher, stacked the stack in the serving line. 12/21/24 between the dishwasher, to a tray. The cups were wet. Dietary Aide 5 grabbed a placed the tray on a cart to dining room. 12/21/23 at 10:57 AM, Dietary cups were still wet. Dietary was okay to use the wet cups to ming room. 12/21/23 at 10:58 AM, Dietary all dishes should be air dried of Manager also indicated wet the service of the service of indicated it was okay to use the wet complete wet the service of indicated it was okay to use the other were food.		be effected by deficient practic Facility removed wet pots, par and dishes from serving area, rewashed and allowed to air d Cook 6 educated on dietary infection control practices. Education provided by dietary manager and DON on 12/29/2 No adverse outcomes identified Measures put into place to ensystemic changes included re-education of dietary related facility policies with respect to complete air drying of dishes provided to utilization, appropriate hand hygiene and glove usage during food service. Education provided by DON and dietary service manager on 12/29/23. Employ will receive ongoing education will be able to demonstrate understanding of policy eleme Administrator, or designee, will audit kitchen for wet dishes, appropriate glove usage, hand hygiene. This audit will be completed weekly for 8 weeks then bi-weekly for 8 weeks, the monthly for 2 months. Any discrepancies will be reported the QAPI committee and additional education provided identified on an individual basi QAPI committee to review aud for pattern/trend and continue recommendations for ongoing improvement.	DATE DEC. DEC.	
	2. During an observ	vation on 12/21/23 at 11:22 AM,		We respectfully request paper compliance.		

compliance.

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL		
		155479	B. WING		12/22/	2023	
NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825				
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	I		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE	
TAG	Cook 6 donned glov plate, grabbed a ski returned with bag o the stove. Cook 6 the chicken and grabbed the chicken up. Cook 6 the same gloved has back on the plate and Another dietary aid cart. Cook 6 did not her gloves during the During an interview Cook 6 indicated he clean. In an interview on 1 Administrator indice food from the kitched A current policy, da "Cleaning Dishesby the Administrator policy indicated to a and prior to putting	ves on both hands, obtained a llet handle, walked away, if bread and placed the bag on men dished up a plate of the then grabbed the chicken with mode and placed the plate on the tray. The placed the plate on the tray in the hall the use hand hygiene or change the observation are observation at 12/21/23 at 11:30 AM, the provided hands were still at 12/21/23 at 1:18 PM, the plated 108 residents received the dished or on 12/21/23 at 12:44 PM. The allow dishes to dry on racks away inspect for dryness.	TAG	Date of Completion: 1/12/202	2.4	DATE	
	Infection Control," Administrator on 12 indicated all staff sh	ated April 2022, titled "Dietary was provided by the 2/21/23 at 12:44 PM. The policy nould wash their hands in an n, such as dirty dishes					
	This citation relates	to Complaint IN00422127.					
	3.1-21(i)(3)						

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