STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155479	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Care Center of Fort Wayne	1010 W Washington Center Rd Fort Wayne, IN 46825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37147 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, 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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)