| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155479 | A. Building<br>B. Wing | 06/25/2025 |

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

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a bed hold policy was given prior to discharge to 3 of 3 residents reviewed. (Resident 26, Resident 28, and Resident 109)<br><br>Findings include:<br><br>1) Resident 26's record review began on 06/20/25 at 01:11 PM. Diagnoses included stroke, heart failure, and seizures.<br><br>A reveiw of progress notes, dated 10/14/24, indicated Resident 26 was sent to the hospital. There was no mention of a bed hold being explained to her or family in the progress or event notes.<br><br>The facility provided an unsigned and undated discharge packet, The notice of transfer and discharge had a section requiring a signature and date which was left blank. The [NAME] Bed Holds and Leaves of Absence form had a place to designate whether the resident or resident representative prefers a bed to be held or do not hold a bed. The Bed Hold form further required a signature and date. On the form given, dated 10/14/24, all of the information was left blank.<br><br>Progress notes indicated, on 11/21/24, Resident 26 was sent to the hospital. There was no mention of a bed hold being explained to her or family in Resident 26's medical record. The facility was unable to provide proof a bed hold was given prior to discharge. There was no discharge packet documented for 11/21/24.<br><br>In an interview, on 06/24/25 at 08:08 AM, the Administrator indicated the facility did not have a bed hold for Resident 26 on the date of 11/21/24. The Administrator indicated the facility attempted to give discharge packets prior to leaving the building when for any reason the facility was not able to mail the form the following day. The Administrator indicated she was unaware of any requirement to show documentation of a bed hold being given or discussed prior to discharge requiring a signature.<br><br>2) Resident 28's record review began on 6/19/25 at 2:35PM. Diagnoses included diabetes, respiratory disease, and heart failure.<br><br>Progress notes indicated Resident 28 was sent to the hospital on [DATE]. There was no mention of a bed hold being explained to him or his family in the medical record.<br><br>(continued on next page) |



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

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Facility provided an unsigned and undated discharge packet. The notice of transfer and discharge had a section requiring a signature and date which was left blank. The [NAME] Bed Holds and Leaves of Absence form had a place to designate whether the resident or resident representative prefered a bed to be held or do not hold a bed. The Bed Hold form further required a signature and date. On the form given for 12/2/24 all of the information was left blank.<br><br>3) Resident 109's record review began on 6/24/25 at 10:22AM. Diagnoses included dementia, heart failure, and respiratory disease.<br><br>Progress notes indicated Resident 109 was sent to the hospital on 4/2/25. There was no mention of a bed hold being explained to her or her family in Resident 26's medical record. The facility was unable to provide proof a bed hold was given prior to discharge. There was no discharge packet found dated 4/2/25.<br><br>In an interview, on 06/24/25 at 11:21 AM, the Administrator indicated no bed hold policy was available dated 4/2/25.<br><br>A current policy titled, Bed Hold, Transfer and Discharge Notice dated March 2025 provided by the Administrator on 6/24/25 at 10:48AM, indicated .at the time of transfer to an Acute Care Facility or in cases of emergency, within 24hours the residing and their representative will be issued the appropriate [NAME] Bed Hold Notice and Bed Hold Policy via the preferred communication method<br><br>No state rule applies. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview and record review the facility failed to ensure facial hair and nail care was provided for 1 of 10 residents reviewed (Resident 41).<br><br>Findings include:<br><br>During an observation, on 6/20/25 at 1:36 PM, Resident 41 was observed in the dining room with many white chin hairs about 2 cm long and dark brown debris present under her first, second, and third fingernails of her right hand.<br><br>During an observation, on 6/23/25 at 9:12 AM, Resident 41 was observed in the dementia care dining room eating her breakfast with dark brown debris under the nails of her right 2nd 3rd and 4th fingernails and 4th and 5th fingernails of her left hand. Her breakfast meal was scrambled eggs and toast, with no food item matching the color of the debris under her nails. Resident 41 had many white hairs about 3 cm long on her chin and upper lip.<br><br>During an interview, on 6/23/25 at 9:23 AM, Certified Nurse Aide (CNA) 4 indicated Resident 41 had dark brown debris under her fingernails on both hands. She indicated it was dark brown and did not match the color of any item she ate that morning. She indicated Resident 41's hands should have been washed and nails cleaned prior to being served her breakfast. She indicated her facial hair was long and should have been groomed. She indicated Resident 41 had not been resistant to facial hair and nail care in the past.<br><br>Resident 41's record was reviewed on 6/20/25 at 2:16 PM. Diagnoses included dementia without behavioral disturbance, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.<br><br>A review of Resident 41's current quarterly Minimum Data Set Assessment (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired). The MDS indicated Resident 41 did not have any occurrences of rejection of care and needed substantial assistance with personal hygiene.<br><br>A review of Resident 41's current care plan titled Resident requires activity of daily living (ADL) assist indicated the resident had a problem of a recent stroke affecting her right side and weakness, with a goal date of 7/5/25. The care plan indicated Resident 41 should receive appropriate assistants for ADLs. Interventions included staff should document the care provided in dressing and grooming.<br><br>Resident 41's current care plan titled Altered cardiac output indicated Resident 41 had a problem of dysarthria, hemiplegia and hemiparesis with a goal date of 7/5/25. Interventions included providing ADL assistance as appropriate.<br><br>A review of progress notes for 6/2025 did not include any documentation of care refusal.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview, on 6/23/25 at 1:48 PM, the Director of Nursing (DON) indicated residents' hands and nails should be clean prior to meal service. Facial hair on female residents should be removed unless they indicate a preference to not receive the care. She indicated care refusal should be documented in the progress notes. She indicated trends of refusal of care or preferences not to receive specific care should be noted in the care plan.<br><br>A current policy, dated 1/24, provided by the Administrator on 6/23/25 at 1:07 PM, indicated facial shaving should be provided to promote cleanliness and provide skin care. The policy indicated any refusals should be documented.<br><br>A current policy, dated 5/23, provided by the Administrator on 6/23/25 at 1:07 PM, indicated nail care included regular cleaning and trimming. The policy indicated debris should be gently removed from under the nails during cleaning.<br><br>3.1-38(a)(3)(D)<br><br>3.1-38(a)(3)(E) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review the facility failed to ensure physician's orders were followed for 1 of 1 residents reviewed. (Resident 112)<br><br>Findings include:<br><br>During an observation, on 06/19/25 at 09:25 AM, the oxygen concentraor in Resident 112's room was turned off, and the nasal cannula was secured in a plastic bag on top of the machine. Resident 112 was in the bed with his eyes closed.<br><br>During an observation, on 06/20/25 at 09:40 AM, the oxygen machine in Resident 112's room was turned off, and the nasal cannula was secured in a plastic bag on top of the machine. Resident 112 was resting in bed. His respirations were easy.<br><br>During an observation, on 06/23/25 at 09:29 AM, oxygen was placed on Resident 112 via nasal cannula at 5LPM (liters per minute).<br><br>Employee 5 indicated in an interview, on 6/23/25 at 9:30 AM, Resident 112 had a change in condition and oxygen was placed on him via nasal cannual at 5LPM.<br><br>During an observation, on 06/23/25 at 01:41 PM, Resident 112's oxygen was running via nasal cannula at a rate of 5LPM.<br><br>During an observation, on 06/24/25 at 08:45 AM, oxygen was placed on Resident 112 via nasal cannual at 5LPM.<br><br>In an interview, on 6/24/25 at 8:46 AM, Employee 5 indicated Resident 112's oxygen was set to 5LPM, and their oxygen saturation was 95%. Employee 5 indicated their oxygen should be set at 2LPM per physician order, then was observed to turn the resident's oxygen down to 2LPM. Employee 5 indicated the oxygen levels should be checked at least once per shift.<br><br>In an interview, on 06/24/25 at 08:56 AM, the Director of Nursing (DON) indicated when a resident requires more or less oxygen than indicated on the physician's order, then they would need to obtain a new physician order.<br><br>Resident 112's record was reviewed on 06/24/25 at 12:30 PM, diagnoses included Parkinson's, restlessness and agitation, and squamous cell carcinoma.<br><br>A review of physician's orders dated 06/24/25 at 12:30 PM indicated oxygen should be titrated via nasal cannula between room air and 2LPM to keep oxygenation greater than or equal to 90% every shift.<br><br>A current policy, dated 06/24/25, provided by the DON, indicated physician orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy. The policy did not indicate physician orders should be followed.<br><br>3.1-47(a)(4)(5)(6) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on record review and interview, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 2 of 3 residents reviewed. (Resident 17 and Resident 163)<br><br>Findings include:<br><br>1) Resident 17's record review began on 06/23/25 at 02:17 PM. Resident 17's diagnoses included end stage renal disease, diabetes, and hypertension. Resident 17 had a physician order for dialysis on Tuesdays, Thursdays, and Saturdays.<br><br>A review of Resident 17's dialysis communication book indicated the Hemodialysis communication forms had the following missing information:<br><br>- 6/14/25 Had no communication from the dialysis center. No vital signs. No weight. No run time. No dry weight. No post dialysis assessment. No information regarding if there were any complications. No information regarding medications given. No information regarding if labs were drawn.<br><br>- 6/17/25 Had no communication from the dialysis center. No vital signs. No weight. No run time. No dry weight. No post dialysis assessment. No information regarding if there were any complications. No information regarding medications given. No information regarding if labs were drawn.<br><br>A review of Resident 17's medical record indicated there was no documentation the facility further attempted to get the information from the dialysis center.<br><br>2) Resident 163's record review began on 06/19/25 at 11:42 AM. Resident 163's diagnoses included end stage renal disease, diabetes, and hypotention. Resident 162 had a physician order for dialysis on Tuesdays, Thursdays, and Saturdays.<br><br>A review of Resident 163's dialysis communication book indicated the Hemodialysis communication forms had the following missing information:<br><br>- 6/14/25 Had no communication from the dialysis center. No vital signs. No weight. No run time. No dry weight. No post dialysis assessment. No information regarding if there were any complications. No information regarding medications given. No information regarding if labs were drawn.<br><br>- 6/17/25 Had no communication from the dialysis center. No vital signs. No weight. No run time. No dry weight. No post dialysis assessment. Indicated medications were given and to see attachment. There was no attachment or medications with dosages written.<br><br>- 6/21/25 the form had vital signs but no weights pre dialysis weight and dry weight to see how much was taken off. There were no post dialysis vital signs. Indicated medications were given and to see attachment. There was no attachment or medications with dosages written.<br><br>A review of Resident 163's medical record indicated there was no documentation the facility further attempted to get the information from the dialysis center.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview, on 06/23/25 at 02:04 PM, the Assistant Director of Nursing (ADON) indicated the importance of communication with the dialysis center was to ensure there were no complications to monitor and to know the follow up required to properly care for the resident. The ADON indicated the expectation was to call the dialysis center and get information, then either write it onto the form or to make a progress note in the resident's medical record.<br><br>A current policy titled Dialysis dated October 2019 indicated The facility shall provide a safe environment for residents receiving treatments, including monitoring the resident before, during, and after dialysis treatments . collaborates with an End Stage Renal Disease facility to provide dialysis care coordination .<br><br>3.1-37(a) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a license was current for 1 of 159 licensed staff. (Qualified Medical Assistant (QMA) 9).<br><br>Findings include:<br><br>A review of the facility licensure book, on [DATE] at 12:PM, indicated QMA 9's license expired on [DATE].<br><br>In an interview, on [DATE] at 1:45PM, the Administrator was informed QMA 9's license was expired.<br><br>In an interview, on [DATE] at 10:30AM, the administrator provided QMA 9's license renewed [DATE]. The Administrator was unsure if QMA 9 had worked any hours while the license was expired.<br><br>In an interview, on [DATE] at 11:15 AM, the DON indicated the dates QMA 9 worked in the facility without a license was [DATE] and [DATE].<br><br>A timesheet was provided by the DON, on [DATE] at 12:18PM, for QMA 9 indicated she had worked on [DATE] and [DATE] administering medications on a hall to 10 residents.<br><br>No policy was provided by time of exit.<br><br>3.1-17(b)(1) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure safe sanitization parameters were maintained for cleaning solutions used in the kitchen. 106 of 109 residents eat food prepared in the facility kitchen.<br><br>Findings include:<br><br>During an observation, on 06/19/25 at 09:15 AM, the following was observed: the Dietary Manager (DM) performed dipstick testing on the red sanitization bucket in the main kitchen. The solution did not cause the test strip to change color. The DM indicated the test strip should change color to confirm the solution is a minimum of 150ppm (parts per million). The DM indicated chemical release towels were used that [NAME] chemical solution into the water in the bucket The bucket was emptied, refilled, and new chemical release towels were placed in the water.<br><br>During an observation, on 06/19/25 at 10:30 AM, the Dietary Manager performed dipstick testing in the main kitchen and the test strip did not change colors. The DM indicated the water still did not meet the minimum requirements of 150ppm. Employee 8 indicated they just changed the bucket with new water and chemical release towels, but the solution did not have time to [NAME] into the water yet.<br><br>During an observation, on 06/19/25 at 11:30 AM, the Dietary Manager performed dipstick testing in the main kitchen and the test strip changed colors to meet minimum parameters for 150ppm. The dipstick test in the sanitization bucket in the secondary kitchen did not change colors to meet the minimum test strength. The DM indicated the solution should meet the minimum strength to effectively sanitize. The bucket was emptied, then taken to the main kitchen and filled from the wall-mounted sanitizer solution dispenser. The solution then was tested at 300ppm.<br><br>There were no policies provided regarding the use of towels as a replacement for wall-mounted sanitization units.<br><br>483.60(i)(1)(2) |