STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINGSTON RESIDENCE OF FORT WAYNE	7515 WINCHESTER RD FORT WAYNE, IN 46819

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00424237 and IN00426197. Complaint IN00424237 - State deficiencies related to the allegations are cited at R0064. Complaint IN00426197 - State deficiencies related to the allegations are cited at R0241. Survey dates: January 29 and 30, 2024. Facility number: 001135 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 31, 2024	R 0000	This Plan of Correction is being prepared and executed because it is required by the provisions of state regulation, and not because Kingston Residence of Fort Wayne agrees with the allegations and citations listed on the statement of deficiencies. Kingston Residence 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 Residence 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 Residence of Fort Wayne reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction of 2/23/24 as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction.	
R 0064	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Craig	Executive Director	02/16/2024

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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Bldg. 00	Based on interview and record review, the facility failed to ensure prevention of theft of personal property for 1 of 1 Resident. (Resident H.) Findings include: A record review began on 1/29/2024 at 11:35 AM. The incident report indicated, on 12/15/2023: Resident H's family member met with Administration and reported the credit card statements showing charges were not made by Resident H. The family member reported last time they saw the credit card was end of November. When they saw the credit card statement they did come to check and noticed the card was in fact missing and not in Resident H's wallet. The Administrator contacted police, filed a police report, met with the Sheriff and provided all information to assist with the investigation. On 12/19/2023, the Sheriff presented a video to the Administrator of an establishment where one of the suspicious charges occurred. The Administrator was able to confirm the person, as one of the employees (Certified Nursing Assistant 7) contracted from an agency to work for the facility. A record review of the credit care statement with suspicious transactions indicated the following: 11/28/2023 of an amount of $179.63. 11/28/2023 of an amount of $10.00. 11/28/2023 of an amount of $2.55. 11/28/2023 of an amount of $28.88. 11/28/2023 of an amount of $21.60. These charges, confirmed by the Administrator, were not made by Resident H. The charges were made by CNA 7. In an interview, on 1/29/2024 at 11:15 AM, the	R 0064	It is the policy of Kingston Residence of Fort Wayne to investigate all allegations involving abuse, neglect, or misappropriation of resident property and to report known or suspected abuse, neglect or misappropriation of resident property in accordance with the law. Resident H has had a review and investigation completed of missing property by Administrator on 12/15/23. Police Report was made with the Allen County Sheriff's Department on 12/14/23. Administrator met with officer at the Sheriff's Office dept on 12/14/23 and provided schedules of staff working during the time of the fraudulent charges and statement of charges. 12/19/23 Sheriffs department provided video footage of same date/time stamp of Resident H credit card statement. Administrator identified agency staff member and provided, identification to officer Moore. On 12/19/23 Niche agency was notified by administrator of the incident with employee and was removed from any current and future shifts. The family was notified of all updates throughout the investigation and son reports resident was reimbursed for charges. Administrator offered to set up trust account or provided lock box on 12/14/23, in which	02/23/2024

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	Administrator, indicated Resident H's family showed the transactions not made by the Resident H. The Sheriff came to the facility with a video, the Administrator saw the video and knew who it was. He identified the person making the charges as CNA 7. CNA 7 was working for the facility through agency, and the Administrator indicated CNA 7 worked at the facility quite a bit. A current facility policy, Abuse, Mistreatment, Neglect and/or Misappropriation of Resident, was provided by the Administrator on 1/29/2024 at 11:35 AM. The policy indicated..."Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the residents consent...." This cittion is related to Complaint IN00424237.		resident and family declined. On 12/15/23, Administrator met with group of like residents to identify any potential or current risks and no concerns were identified. Education was provided to all staff on the misappropriation of resident's funds and property on 12/15/23 by the Administrator. Upon admission residents are offered the chance to set up trust account to protect and monitor funds. The systematic change put in place moving forward will be to offer lock boxes to all residents if requested or needed. Residents and families will be educated upon admission and as necessary and thereafter regarding policy of abuse, mistreatment, neglect and/or misappropriation of resident property by administrator or designee. Upon Hire, employees will receive Kingston policy addressing abuse, mistreatment, neglect and/or misappropriation of resident's property with annual training thereafter. Kingston will continue Pre and Post Hire screening with obtaining 2 references at minimum, in accordance with the state regulation that outlines criminal history checks. The Administrator/designee will monitor compliance by reviewing and meeting with residents monthly during resident council meetings. The	

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			Administrator/designee will also complete a random audit with interviewing residents for any potential related concerns 1 time a week for 4 weeks and then monthly for 4 months. Any findings will be addressed at the time. Completion Date 2/23/24	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, interview, and record review the facility failed to implement interventions to prevent elopement of 1 of 5 resident reviewed. (Resident 7). Findings include: Resident 7's record review, began on 1/29/24 at 11:06 AM, diagnoses included high blood pressure and dementia. Preadmission assessment, dated 11/1/23, indicated Resident 7 resided in a skilled nursing facility's memory care unit prior to admission. There was no documentation on preadmission screening assessment regarding behaviors including wandering and elopement. There were no notes or comments in the behavior /elopement section of the assessment. The admission physician's note from Resident 7's family physician, dated 1/19/24, indicated on 1/12/24 Resident 7 walked out of the facility into the rain approximately 4 miles from the facility. She was picked up by a couple and she did not know where she was going or where she lived. Resident	R 0241	It is the policy of Kingston Residence of Fort Wayne to strive and to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. Resident 7 service plan has been reviewed by DON on 2/12/24 to ensure current elopement risk and updated safety measures are in place. Updated Elopement risk assessment has been completed by DON on 2/12/24. Elopement Risk to be completed monthly for Resident 7 to monitor any new changes or increase in elopement risk, directly related to resident 7 refusing to keep wander guard intact. Current Elopement Risk for resident 7 has decreased and resident continues to be monitored by PCP and Psych NP post infection. Care plan held with family and resident 7, room move offered and declined by resident 7	02/23/2024

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	7 had her cell phone and with assistance of the unknown couple her daughter was called. Resident 7 was given a ride back to the facility. The physician note indicated Resident 7's memory was quite bad during the visit as she was not able to remember much of what she was asked. An elopement risk assessment was not completed after admission or prior to the incident. An elopement risk dated 1/12/24 had a score of 24. The score of 24 indicated Resident 7 was at high risk for elopement. The elopement risk assessment indicate Resident 7 had the following: Mobility 4 pts fully ambulatory. Emotional status 4 pts Voices desires to leave. History of elopement attempts: 10 pts Had made one or more attempts. Medications (Antipsychotic, mood altering) 2 pts takes one of these medications. Behavior modification 2 pts behavior redirected. Diseases (Dementia, any type of mental illness) 2 pts one present. Resident 7 had a physician's order, dated 1/13/24, to check placement of a wander guard (right ankle) and notify the Director of Nursing (DON) and the Administrator if not in place every shift for preventative. The start date for this order was 1/12/24. There was no stop date, but the order was discontinued without a discontinued date shown on the orders. There was no order for a wanderguard prior to 1/13/24. The MAR (Medication Administration Record) documentation indicated the Wanderguard was checked as follows: 1/13/24 Day on, Eve on, Night on 1/14/24 Day on, Eve on, Night on		POA. Resident 7 POA notified of exit near resident 7 apartment and resident 7 POA reports understanding and unawareness of exit near room or concern. Alarm in place on Exit Door near resident 7 room to alert of any opening. Current Residents have been reviewed by the DON on 2/15/23 to identify any elopement and/or safety risks and no concerns were identified. Administrator provided Inservice Education to Kingston staff on 1/12/24 educating on Kingston's policy of Elopement and trigger Events. All Residents will be reviewed for elopement risks at time of admission to facility. The DON/Designee will monitor compliance by auditing and completing elopement risk weekly for 4 weeks, and then monthly for 4 months, or as needed for any new changes. Completion Date 2/23/2024	

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	1/15/24 Day on, Eve on, Night on 1/16/24 Day on, Eve on, Night on 1/17/25 Day on, Eve had an x, night on 1/18/24 Day no, Eve had an x, Night Y (yes on) 1/19/24 Day x, Eve had both off and on documented, Night x 1/20/24 Day off and on documented, Eve x, Night x 1/21/24 Day off, Eve x, Night N/A (not applicable and on 1/22/24 Day off A review of progress notes for the January 1, 2024, to January 29, 2024, indicated: No progress notes prior to 1/12/24 were available for review. A note on 1/17/24 at 11:05 AM Resident removed wander guard, nurse practitioner updated. There was no further documentation of orders, other notifications, or safety measures put into place to show new, effective interventions to prevent elopement. A note on 1/18/24 at 11:22 AM indicated Resident 7 removed the wander guard. No documentation of notifications, orders, or other safety measures put into place to show new, effective interventions to prevent elopement.. A note 1/18/24 at 3:45 PM simply indicated it was an MAR note. There was no documentation regarding placement of wander guard, notifications, orders, or other safety measure put into place. A note 1/20/24 at 5:21 AM indicated the wander guard was not on and the DON was notified. No new interventions to prevent elopement were put into place. There were no nursing, Social Service or IDT progress notes from 1/1/24 through 1/29/24 documented regarding a discussion with Resident 7's physician about the removal or refusal to wear the wander guard, the discontinued order of the			

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	wander guard, or Resident 7's safety going forward. Resident 7's service plan, dated 11/24/23, indicated under the focus of safety a goal of maintaining a safe living environment. An intervention, dated 1/13/24, indicated to achieve this goal the wander guard was to be in place on the right ankle. In an interview, on 1/29/24 at 11:48 AM, the Administrator indicated Resident 7 left about 2 PM was gone approximately 90 minutes, unsupervised, without facility knowledge without a coat on 1/12/24. The Administrator indicated the resident went out the front door at shift change when everyone was distracted. The Administrator indicated Resident 7's POA put an app on Resident 7's phone on 1/13/24 to keep better track of where she was. The Administrator indicated Resident 7 was no longer at risk for an elopement after to treatment for an infection had been completed and Resident 7 was back to baseline. There was no plan for the facility to know her whereabouts. A check of weather. com indicated ambient temperature at 2 PM in Fort Wayne, Indiana on 1/12/24 at 2 PM was 39 degrees. An observation, on 1/29/24 at 12:07 PM, included Resident 7 sitting across from the front door to the facility. There was no one at the desk and many of the staff and other resident were in the dining room for lunch. There was no wanderguard on any wrist, ankle or other location. During an observation and interview, on 1/29/24 at 1:28 PM, in Resident 7's room. she indicated she			

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	went for a walk in the rain to get some fresh air. Resident 7 indicated she got tired of walking and asked some kind looking people for a ride home. Resident 7 indicated she frequently sat at the front door, to be available if needed for anyone's assistance. Resident 7 was not observed to have on a wander guard on either ankle or either wrist. Resident 7 excused herself to go to the bathroom, opened the closet door and began to step in. Resident 7 had a paper sign on the outside of the bathroom door labeled bathroom. Resident 7's apartment was at the farthest end of the hall, within 10 feet of an exit, not frequently traveled. No policies for elopement prevention or adequate supervision were available for review A policy titled, "Missing Resident /Elopement" was provided by the Administrator on 1/29/24 at 3:19 PM. The last approval date was November 2023. The policy indicated ....If an alert resident leaves the facility, it would generally not be considered an elopement, unless the facility is unaware of the resident's departure or whereabouts ....1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing ...2. If an employee sees a resident attempting to leave the premises ho or she should attempt to prevent the departure in a courteous manner ... ... Complaint IN00426197			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained. 50 of 50 residents residning in the facility ate food prepared in the	R 0273	It is the policy of Kingston Residence of Fort Wayne to ensure all food preparation and serving areas (excluding areas in	02/23/2024

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	kitchen. Findings include: During an observation, on 1/29/24 at 9:13 AM, no hairnets were available outside the pantry area. To get to the pantry, the person had to walk through the kitchen. The sink was leaking a steady drip into a half full bucket under the sink. A wet floor sign was placed. There was a puddle the length of the sink approximately 5 feet wide with a rivulet 4 feet wide to the nearest drain. There were food particile varying in size, consistency, and color scattered under the freezer and refrigerators. There were plastic lids for styrofoam containers and other debris under the metal fixture holding clean utensils. The wood structure holding the pans had chipping and bubbled paint. The Dietary Manager indicated, on 1/29/24 at 9:24 AM, the sink had been leaking for the past 2 months and a work order was submitted at the time the leak was noted. In an interview, on 1/29/24 at 10:16AM, the Maintenance Director indicated he did had a work order about the leaking sink approximately 2 months ago. The Maintenance Director indicated his assistant cleaned the trap at the time at the 90-degree angle seal. The Maintenance Director indicated there were no further issues or work orders after the work was completed. During an observation, on 1/29/24 at 11:48AM, the kitchen floor was dry. The sink was taped off with a sign indicating it was not in use. There was no bucket under the sink. In an interview, on 1/30/24 at 9:18AM, the Maintenance Director indicated his assistant just		residents ' units) are maintained in accordance with state and local sanitation and to follow safe food handling standards. Under Freezer and Refrigerator were cleaned out and sanitized on 1/31/2024 by the Dietary Manager. Hair Nets will be accessible at every door entry to the kitchen. All equipment has been repaired and is in working and safe order 1/30/23 by maintenance director. Table holding pans will be sanded down back to original metal and paint will be removed by maintenance team on 2/19/23. New structures for holding pans have been ordered by the administrator on 2/15/23. No residents were affected by the deficient practices, but deficient practice could potentially affect all residents. Dietary staff were educated by dietary manager on 1/31/23 on cleaning schedules and cleaning checklists for daily, weekly, and monthly cleanings. A Quality Assurance Audit has been created to ensure our corrective measures stay corrected. The Administrator /designee will complete the QA audit(s) weekly for 4 weeks and monthly for 4 months. Any deficient practice will be addressed at the time of identification. Completion Date 2/23/24	

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	completed the sink work. He indicated the assistant allowed it to run for 5 minutes and there were no further issues. The maintenance director indicated the seal at the 90degree angle was cracked and replaced. A work order, dated 11/20/23, indicated the sink by the kitchen entry door was leaking. The work order was marked as urgent. On 11/21/23 the work order request indicated the work was completed. A cleaning list with daily tasks was provided. There was no documentation of the tasks being done or of when the cleaning was last done. In an interview, on 1/30/24 at 10:34AM, the Administrator indicated the sink began to leak again and another part was ordered. A policy and procedure titled, "Work Order Request", provided by the Maintenance Director 1/30/24 at 11:04AM last updated 05/2023. The policy indicated, 8. If the equipmennt is not repairable or the maintenance department does not possess the expertise to repair the equipment, the Administrator should be advised to assure that the repair or replacement is done with appropriate approvals....			