

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>10/30/2014 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>KINGSTON AT DUPONT | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|         |  |         |  |  |
|---------|--|---------|--|--|
| R000000 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates:<br/>October 29 &amp; 30, 2014</p> <p>Facility number: 003000<br/>Provider number: 003000<br/>AIM number: N/A</p> <p>Survey team:<br/>Rick Blain, RN - TC<br/>Tim Long, RN<br/>(10/29/2014)<br/>Carol Miller, RN<br/>Diane Nilson, RN</p> <p>Census bed type:<br/>Residential: 39<br/>Total: 39</p> <p>Census payor type:<br/>Other: 39<br/>Total: 39</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on October 31,</p> | R000000 | <p>Enclosed is the plan of correction for the annual survey completed on October 30, 2014. Please consider this the facility's credible allegation of compliance. However, submission of this response and the plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly rendered, and is also not to be constructed as an admission of interest against the facility, the Executive Director or any employees, agent, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency. Rather, this plan of correction has been prepared because the law requires us to prepare a plan of correction for citations regardless of whether we agree with them. Kingston would like to request a desk review as these deficiencies could have been corrected during the survey process if the surveyors had indicated any survey issues.</p> |  |
|---------|--|---------|--|--|

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

TITLE

(X6) DATE

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.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                      |  | X3) DATE SURVEY COMPLETED<br>10/30/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINGSTON AT DUPONT |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |  |   |  |
| (X4) ID PREFIX TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG                                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE  |  |   |  |
| R000026  | <p>2014 by Randy Fry RN.</p> <p>410 IAC 16.2-5-1.2(a)<br/>Residents' Rights - Noncompliance<br/>(a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on observation and interview, the facility failed to ensure the Resident's Rights information was publicly posted for the residents who resided in the facility.</p> <p>This deficiency had the potential to affect 39 of 39 resident's who resided in the facility.</p> <p>Findings include:</p> <p>During the environmental tour on</p> | R000026   | The Resident's Rights information was posted 10/31/14 on a bulletin board in the front entrance area visible for residents and families. The Executive Director or her designee will audit once a month for the next 6 months to ensure the resident's rights remain posted. | 10/31/2014  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>10/30/2014 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>KINGSTON AT DUPONT | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| R000055            | <p>10/30/14 at 10:00 A.M., an observation with the Maintenance Director indicated there was no posting of the Resident's Rights information.</p> <p>On 10/30/14 at 10:15 A.M. an interview with the Executive Director indicated the Resident's Rights information was not posted on the wall in the facility, but was kept in the Survey Book which was located in the Executive Director's office. The Executive Director also indicated there was not a policy in regards to posting the Resident's Rights information.</p> <p>410 IAC 16.2-5-1.2(y)(1-4)<br/>Residents' Rights - Deficiency<br/>(y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following:<br/>(1) Bathing.<br/>(2) Personal care.<br/>(3) Physical examinations and treatments.<br/>(4) Visitations.</p> <p>Based on observation and record review, the facility failed to provide privacy during a blood sugar test for 1 of 1 residents observed for blood sugar testing, Resident, #20.</p> <p>Findings include:<br/><br/>The record for Resident #20 was</p> | R000055       | The Licensed Nursing staff were in-serviced on 11/10/14, to the Resident's Rights to privacy for residents in all areas for care and treatment. The Director of Nursing or her designee will do 3 audits weekly for the first month and then 3 audits monthly for five additional months to ensure staff provide privacy while obtaining the resident's blood sugar. | 11/10/2014           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>10/30/2014 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>KINGSTON AT DUPONT | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| R000414            | <p>reviewed, on 10/29/14, at 1:45 P.M..<br/>Diagnoses included, but were not limited to, dementia. Current physician orders for October 2014 indicated the blood sugar was to be checked twice daily, at 7:00 A.M., and 4:00 P.M.</p> <p>Resident #20 was observed ambulating with her walker in the hallway outside of the Country Kitchen room, on 10/29/14, at 4:10 P.M. RN #1 asked the resident to go into the Country Kitchen room to have her blood sugar testing done. The resident went into the room with two other residents following close beside her. All three residents sat down at a table in the room, along with a family member of one of the residents. The RN sat down next to Resident #20 and proceeded to stick her finger for the blood sugar reading and then use the glucometer to test the resident's blood sugar. The RN then informed the resident, with the family member and 2 other residents still sitting at the table, of the results of the blood sugar reading.</p> <p>410 IAC 16.2-5-12(k)<br/>Infection Control - Deficiency<br/>(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> | R000414       | The Nursing Staff were  | 11/10/2014           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>10/30/2014 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>KINGSTON AT DUPONT | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|                    | <p>Based on observation, record review, and interview, the facility failed to ensure a nursing staff member used gloves when handling a medication for one resident in a sample of 5 residents observed during medication administration (Resident #10). The facility also failed to ensure handwashing was completed before donning gloves prior to checking a blood sugar reading for 1 of 1 Residents (Resident #20) observed for blood sugar testing. The facility also failed to prevent possible contamination of a table surface during a blood sugar test during 1 of 1 observations of blood sugar testing.</p> <p>Findings include:</p> <p>RN #1 was observed during a medication pass on 10/29/14 at 3:45 P.M. The RN opened a bottle of A to Z Select Multi-Vitamins for Resident #10, removed a tablet from the bottle with her bare hands, placed the tablet under the pill cutting device to cut the tablet in half, and then removed the cut tablet with her bare hands and placed it in a medication cup, and proceeded to give the medication to the resident.</p> <p>RN #1 was observed giving a medication to another resident on 10/29/14, at 4:05 P.M., then without washing her hands, proceeded to go to the medication room,</p> |               | <p>in-serviced 11/10/14, to the Hand Hygiene Policy to be used while providing care to a resident. The Nursing staff also were in serviced on the proper technique to be used when medication needs to be split. Administering Oral Medications Policy Attached. The Nursing staff were also in serviced on the policy of how to obtain a blood sugar check correctly. The Director of Nursing or her designee will do 3 audits weekly for the first month and then 3 audits monthly for five additional months to ensure staff follow the proper infection control measures in the above stated areas.</p> |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>10/30/2014 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>KINGSTON AT DUPONT | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|                    | <p>and get a glucometer for Resident #20. She donned gloves but did not wash her hands.</p> <p>Resident #20 was observed ambulating with her walker in the hallway outside of the Country Kitchen room. RN #1 asked the resident to go into the Country Kitchen room to have her blood sugar reading done. The resident went into the room with 2 other residents who were close by, and all three residents sat down at a table in the room along with a family member of one of the residents. The RN sat down next to Resident #20 and proceeded to stick her finger for the blood sugar reading, then use the glucometer to test the blood sugar. She then set the glucometer on the table and gave the resident a Kleenex for her finger. She informed the resident, with the family member and 2 other residents still sitting at the table, of the results of the blood sugar reading. She then left the resident at the table and proceeded back to the medication room.</p> <p>A policy titled Administering Oral Medications, dated April 2014, was provided by the Administrator, on 10/30/14, at 10:05 A.M.</p> <p>The policy indicated for tablets or capsules from a bottle, pour the desired number into the bottle cap and transfer to</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>10/30/2014 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br>KINGSTON AT DUPONT | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|                    | <p>the medication cup. Do not touch the medication with your hands.</p> <p>A second policy Handwashing/Hand Hygiene, dated April 2014, was provided by the Administrator, on 10/30/14, at 10:05 A.M.</p> <p>The policy indicated, "Employees must wash their hands for at least fifteen(15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:<br/>Before and after direct resident contact(for which hand hygiene is indicated by acceptable professional practice);<br/>Before and after performing any invasive procedure(e.g., fingerstick blood sampling)."</p> <p>The policy further indicated, "The use of gloves does not replace handwashing/hand hygiene."</p> |               |   |                      |