STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/02/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00464749 and IN00464838. Complaint IN00464749 - No deficiencies related to the allegations are cited. Complaint IN00464838 - No deficiencies related to the allegations are cited. Survey dates: October 1, & 2, 2025. For Residential Facilities: Census Bed Type: Residential: 56 Total: 56 Census Payor Type: Medicaid: 28 Other: 28	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 10/21/ the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction.	

	Total: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 6, 2025.			
R 0152	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(i) (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection. Based on observation, interviews, and record review, the facility failed to ensure one of one laundry room observed was maintained in a clean and orderly fashion. Findings include: On 10/1/25, at 9:35 AM, an observation of the laundry room was conducted with the Executive Director (ED). A tall, gray trash can was overflowing with multiple trash bags and was not covered by a lid. On the right side of the room, behind the row of four dryers, there was an accumulation of greyish colored dust, lint, and other debris on the floor. An inspection of the first dryer indicated its lint tray , contained	R 0152	It is the practice of Kingston Residence Fort Wayne to ensure proper sanitation and safety standards. The Sanitation concerns in the laundry with linen and trash, identified by surveyor, been educated on and corrected on 10/3/25. This deficient practice had the potential to affect all residents. To correct the deficiency, all laundry cleaning policies and linen cleaning procedures have been reviewed and with all staff. will complete a Quality Assurance Audit to ensure compliance with Sanitation and Safety Standards weekly for 4 weeks, bi-weekly for 4 weeks, and then monthly for 4 months. Any abnormal findings will be addressed at that and re-education will be conducted. The Administrator will report all findings to the QA Committee and will be reviewed at the QA Quarterly Meeting for 6 months.	10/03/2025

	approximately 1/5 inch of lint. A shelf behind this dryer held an unorganized pile of unfolded towels. On the left side of the room, inside the basin of a large, front-load washer, a black residue was visible around the interior barrel. In the center of the room, a laundry pushcart was noted containing unfolded clothes and a bucket with smaller, unfolded towels. The Executive Director indicated she was not sure if the towels were clean or dirty or if they belonged to the facility or the residents. In an interview, on 10/1/25 at 9:34 AM, Certified Nurse Aide 5 (CNA) indicated she was not sure who cleaned the washers but the CNAs were in charge of emptying out the lint trays, not all residents washed their clothes independently, it just depended on their service plan. There were more than 4 residents who used the laundry area. In an interview, on 10/1/25 at 9:35 AM, the ED indicated the washer was not being used and they were supposed to get rid of it, but the maintance person worked 2 days a week so they had not gotten a chance to pull it out. The ED indicated she would speak to housekeeping regarding the cleaning schedule. In an observation, on 10/1/25 at			

	10:01 AM, of two staff members were removing the washer from the laundry room. In an interview, on 10/1/25 at 10:51 AM, Maintenance 8 indicated this was his first day back since the work order was put in. He indicated staff took the washer out and the facility would be getting a new one. A work order request for the laundry room, dated of September 25, 2025, indicated the washer bearings were going out and the facility needed a new washer. The name of the requestor was not specified. The work order was marked as completed by maintenance on October 1, 2025. The maintenance person indicated staff went to the store to purchase a new washer and the old washer had been removed from the building. In an interview, on 10/1/25 at 11:49 AM, the ED indicated behind the dryer the lint tubing was new so they were not sure if it was hooked up correctly. The ED indicated she was not sure whose responsibility it was to clean behind the dryers/washers. The ED consulted the housekeeping cleaning book, but she was not sure when the staff were to clean the laundry room. She thought the staff were to clean twice a week, so she asked			

housekeeping and was waiting to hear back. The ED indicated, she was not sure what in the policy indicated regarding how often the staff were to clean the laundry room. The ED indicated there were in-services for housekeeping as well.

Housekeeping extra tasks, dated September 2025: Essential task, clean beauty shop/laundry, the first was the only date documented as completed. No other dates had initials to document the cleaning had been completed.

Housekeeping extra tasks, dated August 2025: Essential task, clean beauty shop/laundry: the 1st and the 25th were the only dates documented as complete. No other dates had initials to document the cleaning had been completed.

An in-service, titled Detail cleaning, dated 8/13/25 indicated there was information regarding room cleaning schedule, and a detailed cleaning schedule for other areas. There was not an area for the laundry room cleaning to be addressed.

An in-service, titled miss punch forms in phones, dated 9/25/25, did not indicate by whom and when the laundry room would be cleaned.

An in-service, titled extra

	cleaning, dated 8/1/25, did not indicate by whom and when the laundry room would be cleaned. An in-service, titled cleaning bathrooms, dated 8/21/25 did not indicate by whom and when the laundry room would be cleaned. A current facility policy, titled, Laundry Procedures, dated 9/3/25, was provided by the ED on 10/1/25 at 12:34 PM. The policy indicated..."All soiled linen must stay in barrels in the laundry room...All clean linen must stay on the clean side of the laundry room by the dryers...after drying and folding of linens, return linens on covered, clean linen cart...." A current facility policy titled, Cleaning and disinfection of environmental dated 8/25, was provided by the ED on 10/1/25 at 12:34 PM. The policy indicated..."Environment surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OHSA bloodborne pathogens standard...." Based on observation, interviews, and record review, the facility failed to ensure one of one laundry room observed was maintained in a clean and orderly fashion.			

	Findings include: On 10/1/25, at 9:35 AM, an observation of the laundry room was conducted with the Executive Director (ED). A tall, gray trash can was overflowing with multiple trash bags and was not covered by a lid. On the right side of the room, behind the row of four dryers, there was an accumulation of greyish colored dust, lint, and other debris on the floor. An inspection of the first dryer indicated its lint tray , contained approximately 1/5 inch of lint. A shelf behind this dryer held an unorganized pile of unfolded towels. On the left side of the room, inside the basin of a large, front-load washer, a black residue was visible around the interior barrel. In the center of the room, a laundry pushcart was noted containing unfolded clothes and a bucket with smaller, unfolded towels. The Executive Director indicated she was not sure if the towels were clean or dirty or if they belonged to the facility or the residents. In an interview, on 10/1/25 at 9:34 AM, Certified Nurse Aide 5 (CNA) indicated she was not sure who cleaned the washers but the CNAs were in charge of emptying out the lint trays, not all residents washed their clothes independently, it just depended on their service plan. There were more than 4			

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In an observation, on 10/1/25 at 10:01 AM, of two staff members were removing the washer from the laundry room.

In an interview, on 10/1/25 at 10:51 AM, Maintenance 8 indicated this was his first day back since the work order was put in. He indicated staff took the washer out and the facility would be getting a new one.

A work order request for the laundry room, dated of September 25, 2025, indicated the washer bearings were going out and the facility needed a new washer. The name of the requestor was not specified. The work order was marked as completed by maintenance on October 1, 2025. The maintenance person indicated staff went to the store to purchase a new washer and the old washer had been removed from the building.

	In an interview, on 10/1/25 at 11:49 AM, the ED indicated behind the dryer the lint tubing was new so they were not sure if it was hooked up correctly. The ED indicated she was not sure whose responsibility it was to clean behind the dryers/washers. The ED consulted the housekeeping cleaning book, but she was not sure when the staff were to clean the laundry room. She thought the staff were to clean twice a week, so she asked housekeeping and was waiting to hear back. The ED indicated, she was not sure what in the policy indicated regarding how often the staff were to clean the laundry room. The ED indicated there were in-services for housekeeping as well. Housekeeping extra tasks, dated September 2025: Essential task, clean beauty shop/laundry, the first was the only date documented as completed. No other dates had initials to document the cleaning had been completed. Housekeeping extra tasks, dated August 2025: Essential task, clean beauty shop/laundry: the 1st and the 25th were the only dates documented as complete. No other dates had initials to document the cleaning had been completed. An in-service, titled Detail			

cleaning, dated 8/13/25 indicated there was information regarding room cleaning schedule, and a detailed cleaning schedule for other areas. There was not an area for the laundry room cleaning to be addressed.

An in-service, titled miss punch forms in phones, dated 9/25/25, did not indicate by whom and when the laundry room would be cleaned.

An in-service, titled extra cleaning, dated 8/1/25, did not indicate by whom and when the laundry room would be cleaned.

An in-service, titled cleaning bathrooms, dated 8/21/25 did not indicate by whom and when the laundry room would be cleaned.

A current facility policy, titled, Laundry Procedures, dated 9/3/25, was provided by the ED on 10/1/25 at 12:34 PM. The policy indicated..."All soiled linen must stay in barrels in the laundry room...All clean linen must stay on the clean side of the laundry room by the dryers...after drying and folding of linens, return linens on covered, clean linen cart...."

A current facility policy titled, Cleaning and disinfection of environmental dated 8/25, was provided by the ED on 10/1/25 at 12:34 PM. The policy

	indicated..."Environment surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OHSA bloodborne pathogens standard...."			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on Observation, interview and record review the facility failed to ensure proper labeling on opened medications for 1 of 1 residents reviewed. (Resident 19) Findings include: During an observation, on 10/01/2025 at 12:21 PM, Resident 19's long-acting insulin was not labeled with an open or discontinued date. Resident 19 had second long-acting insulin pen not labeled with an open or discontinued date. Resident 19's record was	R 0300	It is the practice of Kingston Residence Fort Wayne to ensure labeling and dating of medications. The Pharmaceutical Services concerns deficiency of labeling and dating medication, specifically insulin pen of Resident 19, identified by surveyor, has been educated on and corrected on 10/2/25. This deficient practice had the potential to affect all residents. To correct the deficiency, medication handling, storage and labeling procedures have been reviewed and with all nursing staff. To prevent further issues, DON will submit an audit schedule with dates and sign offs to Director for weekly review times . The DON will be responsible for reviewing proper labeling and medication dating. Any findings will be addressed at the and re-education will be conducted. will complete a Quality Assurance Audit to ensure compliance with Sanitation and Safety Standards weekly for 4 weeks, and then monthly for 4 months. Any abnormal findings will be addressed at the and re-education will be conducted. The Administrator will report all findings to the QA Committee and	10/02/2025

	reviewed on 10/01/2025 at 1:00 PM. Diagnoses included type 2 diabetes, anxiety disorder, and chronic kidney disease. A review of physician orders, dated 10/02/2025 at 10:15 AM, indicated Resident 19 was insulin dependent and required use of long acting and short acting insulins. In an interview, on 10/01/2025 at 12:42 PM, Employee 3 indicated she returned the full long-acting insulin pen to Resident 19's box due to the medication not being used at this time. Employee 3 was unsure when the long-acting insulin pen was put into the cart or why it was open. A current policy dated 09/2022 provided by the Administrator indicated the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. 410 IAC 16.2-5-6(c)(4) Based on Observation, interview and record review the facility failed to ensure proper labeling on opened medications for 1 of 1 residents reviewed. (Resident 19) Findings include:		will be reviewed at the QA Quarterly Meeting for 6 months.	

	During an observation, on 10/01/2025 at 12:21 PM, Resident 19's long-acting insulin was not labeled with an open or discontinued date. Resident 19 had second long-acting insulin pen not labeled with an open or discontinued date. Resident 19's record was reviewed on 10/01/2025 at 1:00 PM. Diagnoses included type 2 diabetes, anxiety disorder, and chronic kidney disease. A review of physician orders, dated 10/02/2025 at 10:15 AM, indicated Resident 19 was insulin dependent and required use of long acting and short acting insulins. In an interview, on 10/01/2025 at 12:42 PM, Employee 3 indicated she returned the full long-acting insulin pen to Resident 19's box due to the medication not being used at this time. Employee 3 was unsure when the long-acting insulin pen was put into the cart or why it was open. A current policy dated 09/2022 provided by the Administrator indicated the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.			

	410 IAC 16.2-5-6(c)(4)			
R 0353	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(f) (f) The facility shall have a policy that ensures the staff has sufficient information to meet the residents ' needs. Based on interview and record review, the facility failed to maintain current information in the emergency file book related to hospital preference, for 6 of 6 residents reviewed (Resident 3, Resident 10, Resident 15, Resident 16, Resident 17, and Resident 18). Findings include: During a review of the emergency file book on 10/01/25 at 1:55 PM., 6 residents lacked hospital preference on their emergency file. Review of Resident 3's emergency file, dated 3/25/25, did not have a hospital preference listed. Review of Resident 10's emergency file, dated 12/9/22, did not have a hospital preference listed. Review of Resident 15's emergency file, dated 3/25/25, did not have a hospital	R 0353	It is the practice of Kingston Residence of Fort Wayne to ensure proper updated records on facilities emergency file book. The Clinical records noncompliance deficiency of updating hospital preference, specifically on Residents 3,10,15,16,17,18 identified by surveyor, has been educated on and corrected on 10/2/25. This deficient practice had the potential to affect all residents.To correct the deficiency, file book has been reviewed and updated.To prevent further issues, DON will submit an audit schedule with dates and sign offs to Director for weekly review times . The DON will be responsible for reviewing and updating Emergency File book. Any findings will be addressed at the and re-education will be conducted. will complete a Quality Assurance Audit to ensure compliance with Sanitation and Safety Standards weekly for 4 weeks, and then monthly for 4 months. Any abnormal findings will be addressed at the and re-education will be conducted. The Administrator will report all findings to the QA Committee and will be reviewed at the QA Quarterly Meeting for 6 months.	10/02/2025

	preference listed. Review of Resident 16's emergency file, dated 10/1/25, did not have a hospital preference listed. Review of Resident 17's emergency file, dated 6/18/21, did not have a hospital preference listed. Review of Resident 18's emergency file, dated 8/24/23,did not have a hospital preference listed. In an interview, on 10/1/25 at 1:55 PM, Licensed Practal Nurse (LPN) 2 indicated the were no other emergency file books located in the facility. In an interview, on 10/1/25 at 2:10 PM, the Executive Director (ED) indicated there were just a few residents without hospital preference listed but the rest did have it. In an interview on 10/2/25 at 8:40 AM, the ED indicated they did not have a facility policy for emergency file completion.			

Based on interview and record review, the facility failed to maintain current information in the emergency file book related to hospital preference, for 6 of 6 residents reviewed (Resident 3, Resident 10, Resident 15, Resident 16, Resident 17, and Resident 18).

Findings include:

During a review of the emergency file book on 10/01/25 at 1:55 PM., 6 residents lacked hospital preference on their emergency file.

Review of Resident 3's emergency file, dated 3/25/25, did not have a hospital preference listed.

Review of Resident 10's emergency file, dated 12/9/22, did not have a hospital preference listed.

Review of Resident 15's emergency file, dated 3/25/25, did not have a hospital preference listed.

Review of Resident 16's emergency file, dated 10/1/25, did not have a hospital preference listed.

Review of Resident 17's emergency file, dated 6/18/21, did not have a hospital preference listed.

	Review of Resident 18's emergency file, dated 8/24/23,did not have a hospital preference listed. In an interview, on 10/1/25 at 1:55 PM, Licensed Practal Nurse (LPN) 2 indicated the were no other emergency file books located in the facility. In an interview, on 10/1/25 at 2:10 PM, the Executive Director (ED) indicated there were just a few residents without hospital preference listed but the rest did have it. In an interview on 10/2/25 at 8:40 AM, the ED indicated they did not have a facility policy for emergency file completion.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAmanda	TITLECraig	(X6) DATE10/21/2025