

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER KINGSTON SENIOR LIVING OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 the Investigation of Intake 471215. Intake 471215 - Deficiencies related to the allegations are cited at R0052. Survey date: August 13, 2026 Facility number: 1135 Census Bed Type: Residential: 51 Total: 51 Census Payor Type: Medicaid: 29 Other: 22 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed	R 0000	This plan of correction shall operate as Kingston Senior Livings written credible allegations of compliance. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Kingston Senior Living reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction of 8/19/26, the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	August 13, 2026			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to follow elopement protocol. Resident B was unsupervised and walked 1.8 miles across heavily traveled streets. Resident B's unsupervised walking could result in death. Findings included: Resident B's record was reviewed on 8/13/26 at 9:04 a.m. Resident B had a diagnosis of dementia. Resident B's service plan, dated 7/30/26, did not indicate Resident B was at risk for unsafe wandering. The plan indicated Resident B was	R 0052	1. Corrective Action for Residents Found to be Affected The resident involved in the event was located and assessed for any adverse effects related to the incident. The resident's care plan, elopement risk assessment, and safety interventions were reviewed and updated as needed to address identified risks. The incident was reviewed with involved staff, and education was provided regarding the Missing Resident/Elopement Protocol and expectations for response to Wander Guard alarm activation. 2. Identification of Other Residents Who May Be Affected All current residents were reviewed by the Director of Health Services to identify residents at risk for wandering or elopement. At that time, no residents were identified as being at risk. Assessments will be completed for residents upon admission and for change of condition and care plans will be updated as needed. 3. Systemic Changes to Prevent Recurrence	08/18/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

pleasantly confused.

An elopement risk assessment, dated 7/31/26 at 3:09 PM, identified exit seeking, wandering, and elopement risk. There was not a risk assessment completed prior to the 7/31/26 assessment.

Progress notes, dated 7/31/26 at 5:46 a.m., indicated Resident B was found in the hall wearing a shirt and boxer briefs while searching for his wife.

Progress notes dated, 7/31/26 at 1:10 p.m., indicated an order for a wander guard was obtained and the wandergaurd was applied.

The facility has implemented the following corrective measures:

Staff, including licensed nurses, certified nursing assistants, ancillary staff, management personnel, and agency staff, received re-education on the Missing Resident/Elopement Protocol.

Education will include staff responsibilities when a Wander Guard alarm is activated, immediate initiation of the Missing Resident procedure, completion of resident head counts, search procedures, communication requirements, and notification processes.

Staff completed a post-education knowledge assessment and must achieve a score of 100%. Any staff not meeting the required score will receive additional education and retesting prior to independent assignment.

Elopement drills conducted on all shifts to validate staff understanding and response to the protocol.

New staff and agency personnel will receive education on the Missing Resident/Elopement Protocol during orientation before working independently.

During an interview, on 8/13/26 at 9:46 a.m., the Administrator reported Resident B exited the facility through the front door on 8/1/26 at about 5:45 PM. The alarm sounded and staff responded, looked outside, then silenced the alarm and returned to their tasks after being told Resident B was in the dining room. The Administrator indicated Resident B walked approximately 1.8 miles. She indicated Resident B was missing about 45 minutes until the Fort Wayne Police Department returned him to the facility. The facility was unaware of the elopement until Resident B's daughter called to report he had been found.

In an interview, on 8/13/26 at 10:02 AM, CNA 2 indicated she heard the alarm sound on 8/1/26 at about 5:45 PM and looked out the door, but noone could be seen. She indicated CNA 3 told her Resident B was in the dining room and the door was not functioning properly.

In an interview, on 8/13/26 at 10:13 AM, CNA 3 indicated she heard the alarm and saw CNA 2 looking out the door. She indicated she had seen everyone in the dining room moments before, so noone could have went out the front door. She indicated she did not look to see if a resident had

4. Monitoring and Quality Assurance

To ensure ongoing compliance:

The DHS or designee will conduct staff interviews and knowledge validation regarding the Missing Resident/Elopement Protocol three times weekly for three months.

The DHS or designee will review residents identified as having elopement risk to ensure assessments, care plans, and interventions remain current and effective.

Elopement drill results will be reviewed for compliance with protocol requirements and opportunities for improvement. Any identified concerns will result in immediate corrective action and additional staff education as needed.

Elopement drills will be conducted quarterly January through March, Monthly April-September and Quarterly October through December. The Executive Director or Designee will oversee these drills. This will take place indefinitely until further notice or our current policy is updated or changed.

The Administrator will oversee compliance activities and determine if additional interventions are necessary to

went out the door. The Administrator indicated the facility assessed all current residents for elopement risk, educated the staff to look whenever a door alarm sounds, and was completing drills to monitor response as a prevention measure.

A police report was obtained from the Fort Wayne Police Department on 8/13/26 at 4:45 p.m. The report indicated on 8/1/26 at 6:53 PM, Resident B was walking in a construction area and attempted to enter a random vehicle stopped at a busy intersection. Upon police arrival, Resident B stated he was going home to the yellow house two doors down. When asked for his address, the information did not match the location of the yellow house, nor did it align with a walkable distance to be traveled. The officer described Resident B as unsteady on his feet and walking in an active construction zone with deep holes and missing sidewalk sections along the route. When Resident B was returned to the facility, a staff member indicated the resident must have taken off his monitor, but the wanderguard was found in place. The police report listed the distance traveled as 1.8 miles, with an estimated walking time of approximately 41 minutes. The report indicated

maintain ongoing compliance.

5. Completion Date

All corrective audits and systemic changes outlined in this Plan of Correction will be completed by August 19, 2026.

The Plan of Correction is submitted as the facility's credible allegation of compliance. Submission of this Plan of Correction does not constitute admission of the deficiencies cited.

the officer returned Resident B to the facility on 8/1/26 at 7:42 PM. The report indicated the resident was dressed in clean moist clothing, appropriate for the weather.

Resident B was missing from 5:45 p.m. until the Fort Wayne Police Department located him at 6:53 p.m., one hour and 8 minutes later.

Resident B was discharged into the care of the daughter.

A policy and procedure, titled Elopement Risk Assessment and Prevention, revised 11/18/25, was provided on 8/13/25 at 11:59am. The policy indicated a process to assess all residents for risk of elopement, implement prevention strategies for those identified as an elopement risk, institute measures for resident identification at time of admission, and conduct a missing resident procedure. 1. Each resident will be assessed for elopement risk upon admission.

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
SIGNATURE Amanda Craig

TITLE Executive Director

(X6) DATE 09/03/2026