STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON AT DUPONT	1716 E DUPONT RD, FORT WAYNE, , 46825

(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. Survey dates: March 24 and 25, 2025. Facility number: 003000 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 31, 2025	R 0000	The Plan of correction is being prepared and executed because it is required by the provisions of state regulation, and not because Kingston at Dupont agrees with the allegations and citations listed on the statement of deficiencies. Kingston at Dupont maintains that 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 at Dupont'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 at Dupont reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction of 4/23/25, as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction.	

R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a	R 0121	Employee 17 and 18 completed the annual TB symptoms questionnaire. All employee records have been audited for annual TB test compliance. At each employee's annual evaluation we will ensure that each employee completes the TB Symptom Questionnaire to stay in annual compliance. Managers have been educated on the annual TB symptom questionnaire process. The executive director/designee will complete a quality assurance audit to ensure compliance with the annual TB questionnaires, weekly for 4 weeks, bi-weekly for 4 weeks and then monthly for 4 months. Any record out of compliance will be addressed at the time and re-education will be conducted as needed. The audit findings will be reported to the Executive Director/Designee and will be reviewed with managers in department head meetings for 6 months.	04/23/2025

	health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to maintain health reports related to annual tuberculosis screening for 2 of 5 employees reviewed (License practical nurse (LPN) 17, and Certified nursing assistant (CNA) 18). A record review on 3/24/25 indicated LPN 17, hired on 10/26/2022, did not have documentation of an annual tuberculosis screening completed in 2024. A record review on 3/24/25 indicated CNA 18, hired on 6/22/2020 did not have documentation of an annual tuberculosis screening completed in 2024. In an interview, on 3/25/25 at 11:05 AM, the Human Resource Director indicated LPN 17 and CNA 18 did not have records for tuberculosis screening annual risk assessment due in 2024. A current policy, titled			

	"Tuberculosis, Employee Screening (Indiana)", received on, 3/24/25 at 11:07 AM, from the Human Resource Director, indicated tuberculosis would be screened on the anniversary date of hire for all employees. Based on record review and interview, the facility failed to maintain health reports related to annual tuberculosis screening for 2 of 5 employees reviewed (License practical nurse (LPN) 17, and Certified nursing assistant (CNA) 18). A record review on 3/24/25 indicated LPN 17, hired on 10/26/2022, did not have documentation of an annual tuberculosis screening completed in 2024. A record review on 3/24/25 indicated CNA 18, hired on 6/22/2020 did not have documentation of an annual tuberculosis screening completed in 2024. In an interview, on 3/25/25 at 11:05 AM, the Human Resource Director indicated LPN 17 and CNA 18 did not have records for tuberculosis screening annual risk assessment due in 2024. A current policy, titled "Tuberculosis, Employee Screening (Indiana)", received on, 3/24/25 at 11:07 AM, from the Human Resource Director, indicated tuberculosis would be			

	screened on the anniversary date of hire for all employees.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review the facility failed to	R 0356	Resident 10 and 30's clinical record was updated with their hospital preference. All resident clinical records have been audited to ensure hospital preference is present. Upon admission executive director/designee will ensure that each resident's clinical record has their hospital preference present. The executive director/ designee will complete a quality assurance audit to ensure that every resident's clinical record has their hospital preference present, weekly for 4 weeks, bi-weekly for 4 weeks and then monthly for 4 months. Any clinical record out of compliance will be addressed at the time and re-education will be conducted as needed. The audit findings will be reported to the executive director/designee and will be reviewed with managers in department head meetings for 6 months.	04/23/2025

ensure a hospital preference was available in emergency files for 2 of 5 residents reviewed (Resident 10, and Resident 30).

Findings include:

1) Resident 10's record was reviewed on 3/25/25 at 9:32 AM. Diagnoses included Alzheimer's disease, depression and osteoporosis.

A review of the Resident Emergency Files book indicated Resident 10's hospital preference was not included in her emergency file.

2) Resident 30's record was reviewed on 3/25/25 at 9:34 AM. Diagnoses included other amnesia, tranisient cerebral ischemic attack, and muscle wasting and atrophy.

A review of the Resident Emergency Files book indicated Resident 30's hospital preference was not included in her emergency file.

During an interview. on 3/25/25 at 9:44 AM, the Director of Nursing (DON) indicated he was unable to find a hospital preference on the Emergency file forms for Resident 10 and Resident 30. He indicated a hospital preference should be recorded on the emergency file form.

During an interview, on 3/25/25

at 10:01 AM, the Director of Nursing indicated a policy pertaining to emergency files was not available for review. The DON indicated the regulations require a hospital preference to be present in the resident's emergency file.

Based on interview and record review the facility failed to ensure a hospital preference was available in emergency files for 2 of 5 residents reviewed (Resident 10, and Resident 30).

Findings include:

1) Resident 10's record was reviewed on 3/25/25 at 9:32 AM. Diagnoses included Alzheimer's disease, depression and osteoporosis.

A review of the Resident Emergency Files book indicated Resident 10's hospital preference was not included in her emergency file.

2) Resident 30's record was reviewed on 3/25/25 at 9:34 AM. Diagnoses included other amnesia, tranisient cerebral ischemic attack, and muscle wasting and atrophy.

A review of the Resident Emergency Files book indicated Resident 30's hospital preference was not included in her emergency file.

During an interview. on 3/25/25

	at 9:44 AM, the Director of Nursing (DON) indicated he was unable to find a hospital preference on the Emergency file forms for Resident 10 and Resident 30. He indicated a hospital preference should be recorded on the emergency file form. During an interview, on 3/25/25 at 10:01 AM, the Director of Nursing indicated a policy pertaining to emergency files was not available for review. The DON indicated the regulations require a hospital preference to be present in the resident's emergency file.			

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	TITLE	(X6) DATE