STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/10/2025

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 the Investigation of Intakes 465983 and 466983.. Intake 465983 - State deficiencies related to the allegations are cited at R0052. Intake 466983 - No deficiencies related to the allegations are cited. Survey date: December 10, 2025 Facility number: 003000 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 12, 2025	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	This Plan of correction is being prepared and executed because it is required by the provisions of state regulation, and not because	12/19/2025

	(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 observation, interview and record review, the facility failed to ensure residents were free from abuse when a staff member was verbally and physically aggressive towards 1 of 3 residents reviewed for abuse (Resident B). Findings include: A facility report, dated 11/10/25, indicated a potential allegation of abuse had been reported between Certified Nurse Aide (CNA) 3 and Resident B. On 12/10/25 at 2:36 P.M., Resident B's record was reviewed. Diagnoses included Alzheimer's dementia and major depressive disorder. A Service Plan, dated 10/14/25, indicated Resident B had behaviors of aggression and combativeness towards staff during personal care. Goals included the resident having decreased frequency and		Kingston at Dupont agrees with the allegations and citations listed on the statement of deficiencies. Kingston at Dupont remains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate 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 11/11/25, as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction. Resident B was assessed for any injuries, including psychosocial wellbeing. All patients have the potential to be affected. Staff were in-serviced on abuse reporting and caring for residents with dementia. Accused CNA was suspended pending investigation. CNA that reported the abuse received a 1:1 education on reporting timely. Patients were interviewed to ensure that all felt safe, and there were no further concerns with allegations of abuse. No concerns were voiced during interviews. The director of nursing/designee will be	

	severity of behavior episodes and staff demonstrating consistent approaches to behavior management to support the resident's well being. Interventions included: Ensure a safe environment; identify and document triggers for behavioral episodes; use consistent communication strategies (calm tone, clear instruction, and reassurance) across all staff; monitor and manage physical needs; offer re-direction during escalating behaviors; provide structured daily routines to reduce anxiety; and staff to use de-escalation techniques to calm and change the resident's focus. On 12/10/25 at 2:19 P.M., Resident B was observed seated in a chair in the bird lounge with 3 other residents. Her eyes were closed, her head slumped forward and she appeared to be sleeping. -At 2:39 P.M., a resident was overheard yelling out in the bird lounge. The Director of Nursing (DON) was observed escorting Resident B out of the lounge and down the hallway towards her room. -At 2:50 P.M., Resident B was observed to sit down in a chair in the lobby, next to another resident seated in a chair holding a toy puppy. Resident B would yell out garbled words		responsible for ensuring that new employees are always trained on abuse reporting and caring for residents with dementia. The director of nursing/designee will complete a quality assurance audit. The director of nursing/designee will interview five residents to ensure they feel safe and no concerns of allegations of abuse. The director of nursing will do this every week for four weeks, and then monthly for two months. Any abnormal findings will be addressed at the time, and re-education will be conducted along with any appropriate reporting.	

approximately every 20 seconds. The resident seated next to Resident B, had a frown on her face and kept looking over at Resident B every time she would yell out. The other resident became fidgety, playing with a blanket nearby and reaching out towards Resident B. A staff member intervened and directed the other resident to the activity room. Resident B continued sitting in the lobby and yelling out garbled words.

Nurse notes, dated 10/10/25 to 11/8/25, indicated Resident B had several behaviors including wandering into other resident rooms, taking items from various places in the building, poor sleeping at night, agitation, combativeness with personal care, refusing medications, wanting to leave the building, asking staff if they were going to kill her, pinching and cursing staff with hands-on personal care.

A Nurse note, dated 11/9/25 at 12:30 p.m., indicated Resident B had been very agitated. She was yelling profanities and could not be re-directed. The psychiatric Nurse Practitioner (NP) was notified and new order given for Haldol (anti-psychotic) 5 milligrams (mg) intramuscularly (IM) to be given every 8 hours as needed.

A Medication Administration

Record (MAR) dated November 2025, indicated Haldol 5 mg IM was administered on 11/9/25 at 12:45 p.m.

A psychiatric NP progress note, dated 11/9/25 at 5:10 p.m., indicated Resident B was seen for follow up of behaviors and use of Haldol IM for anxious paranoia and insomnia. She was visited while seated and eating a cookie. She was calm and cooperative with no acute distress observed. She had no apparent recall of recent events or show symptoms of psychological distress.

A written statement by CNA 3, indicated on 11/9/25, she and CNA 5 went to Resident B's room close to lunch and tried to assist Resident B to the bathroom where she became very aggressive, hitting, pinching and trying to spit on the CNA while being provided care. The resident sat herself down on the floor in the bathroom. Neither CNA 3 nor CNA 5 could get her back up and onto the toilet so CNA 7 was asked to come and help. While getting her up onto the stool, Resident B kept pinching CNA 3's arm several times. CNA 3 indicated using a loud, stern voice to stop pinching. After lunch, she assisted CNA 5 in getting Resident B out of the dining room because she had been yelling while other

residents were trying to visit with their families. CNA 3 and CNA 5 walked with the resident back to her room, assisted her in and then shut her door. After taking her back to her room, CNA 5 assisted the nurse when asked to hold the resident's hands while she was given an injection. An addendum to her statement on 11/9/25 by CNA 3, indicated she had also helped CNA 5 to get the resident out of bed prior to going to the bathroom. The resident had been aggressive and tried to bite the CNA so she grabbed the resident's arm, pushed it towards the resident's own mouth, and told her not to bite. CNA 3 indicated she understood she shouldn't have pushed the resident's arm towards her mouth but it was her reaction to Resident B's countless attempts to hurt and bite her.

A written statement by CNA 5, indicated on 11/9/25, while trying to get Resident B out of bed, CNA 3 grabbed Resident B's face/chin, hard enough to make the resident's lips pucker, and held it there for several seconds before letting go. CNA 3 told the resident if she kept "acting that way", she was "gonna find out" in a threatening manner. CNA 3 and CNA 5 got the resident into the bathroom where Resident B continued to be aggressive. CNA 7 came to the room to assist the 2 CNA's.

While in the bathroom, CNA 3, grabbed the resident's face/chin and held it for several seconds.

A written statement by CNA 7 indicated she had gone to Resident B's bathroom to assist CNA 3 and CNA 5 with toileting the resident. When entering the room, CNA 7 observed the resident naked and sitting on the bathroom floor. Before lifting the resident onto the stool, CNA 3 was observed to put her hand around the resident mouth/chin and say "stop trying to bite".

On 12/10/25 at 2:26 P.M., CNA 5 was interviewed. She indicated while attempting to get Resident B out of bed and while in the bathroom, the resident was very agitated and aggressive. Resident B tried to hit and bite as she was being assisted. CNA 5 indicated CNA 3 had grabbed the resident's mouth/chin causing her lips to pucker twice while providing care and had yelled at the resident. She indicated being so taken back by the other CNA's actions, she hadn't thought to immediately get the nurse but had reported at the end of her shift.

A current facility policy, titled "Abuse, Mistreatment, Neglect and/or Misappropriation of Property" was provided on 12/10/25 at 2:57 P.M., by the DON which indicated abuse,

neglect, and mistreatment of residents was not permitted or tolerated at the facility.

This Citation relates to Intake IN00465983.

Based on observation, interview and record review, the facility failed to ensure residents were free from abuse when a staff member was verbally and physically aggressive towards 1 of 3 residents reviewed for abuse (Resident B).

Findings include:

A facility report, dated 11/10/25, indicated a potential allegation of abuse had been reported between Certified Nurse Aide (CNA) 3 and Resident B.

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A Service Plan, dated 10/14/25, indicated Resident B had behaviors of aggression and combativeness towards staff during personal care. Goals included the resident having decreased frequency and severity of behavior episodes and staff demonstrating consistent approaches to behavior management to support the resident's well being. Interventions included: Ensure a safe environment;

identify and document triggers for behavioral episodes; use consistent communication strategies (calm tone, clear instruction, and reassurance) across all staff; monitor and manage physical needs; offer re-direction during escalating behaviors; provide structured daily routines to reduce anxiety; and staff to use de-escalation techniques to calm and change the resident's focus.

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-At 2:39 P.M., a resident was overheard yelling out in the bird lounge. The Director of Nursing (DON) was observed escorting Resident B out of the lounge and down the hallway towards her room.

-At 2:50 P.M., Resident B was observed to sit down in a chair in the lobby, next to another resident seated in a chair holding a toy puppy. Resident B would yell out garbled words approximately every 20 seconds. The resident seated next to Resident B, had a frown on her face and kept looking over at Resident B every time she would yell out. The other resident became fidgety, playing

with a blanket nearby and reaching out towards Resident B. A staff member intervened and directed the other resident to the activity room. Resident B continued sitting in the lobby and yelling out garbled words.

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This Citation relates to Intake IN00465983.

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 SIGNATUREDorian Shoemaker	TITLEExecutive Director	(X6) DATE01/08/2026