STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155479	A. BUILDING 00 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINGSTON CARE CENTER OF FORT WAYNE	1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00408892. Complaint IN00408892 - Federal/state deficiencies related to the allegations are cited at F600. Survey date: May 30, 2023. Facility number: 000522 Provider number: 155479 AIM number: 100267040 Census Bed Type: SNF: 48 SNF/NF: 66 Total: 114 Census Payor Type: Medicare: 33 Medicaid: 63 Other: 18 Total: 114 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 31, 2023	F 0000	This Plan of Correction is being prepared and executed because it is required by the provisions of state regulation, and not because Kingston Care Center of Fort Wayne agrees with the allegations and citations listed on the statement of deficiencies. Kingston Care Center 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 Care Center 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 Care Center of Fort Wayne reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction 06/12/2023, as the facility's credible allegation of compliance. We respectfully request paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alicia Holifield	HFA	06/12/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review the facility failed ensure freedom from verbal abuse for 1 of 3 residents reviewed (Resident B). Findings include: In an interview on 5/30/23 at 9:34 AM, Resident B indicated Certified Nursing Aide (CNA) 4 had walked by her room often and made disrespectful statements relating to Resident B's need for care in a rude tone. Resident B indicated she had not responded and tried to ignore the comments, but the comments made her feel low. Resident B indicated she refused to receive care from CNA 4. In an interview on 5/30/23 at 10:33 AM, Respiratory Therapist (RT) 3 indicated on 5/18/23 she had started a breathing treatment on Resident B then the resident indicated she needed to use the bathroom. CNA 4 assisted Resident B to the bathroom. RT 3 indicated she had overheard CNA 4 make multiple comments about how Resident B	F 0600	It is the policy and practice of Kingston Care Center of Fort Wayne to provide residents with an environment that is free from Abuse, Neglect, and Exploitation. Further extending, Kingston Care Center of Fort Wayne policies are to provide the resident the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in subpart §483.12. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The incident described by the surveyor was a facility, self-reported incident, whereas the facility followed all state reporting	06/12/2023

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	had been to the bathroom multiple times. RT 3 indicated she heard CNA 4 yell at the resident while she stood outside the room. RT 3 indicated she heard CNA 4 indicate "all you did was b** and complain" toward Resident B. Resident B said it back to CNA 4. At that time RT 3 intervened. RT 3 indicated Resident B had cried and was upset. RT 3 then reported the incident to the Administrator. RT 3 indicated all residents should be treated with respect. A reported incident, dated 5/18/23, was provided by the Administrator on 5/30/23 at 10:46 AM. The report indicated RT3 had been outside Resident B's room and overheard CNA 4 tell the resident "all you do is b****, b****, b****." An investigation file was provided by the Administrator on 5/30/23 at 10:46 AM. The file included statements. the statements indicated the following: RT 3's statement, dated 5/18/23, indicated around 7:05 AM, Resident B had asked to be taken to the bathroom. RT 3 indicated CNA 4 yelled at Resident B and indicated she was just in her room minutes prior. CNA 4 indicated "she couldn't keep coming in every 5 minutes." Resident B's door was shut and RT 3 was outside the room charting. RT 3 overheard CNA 4 yell at Resident B for "b****ing and complaining all the time." RT 3 intervened and CNA 4 left the room. RT 3 also indicated Resident B was upset and cried. The Director of Nursing's statement indicated on 5/18/23 RT 3 reported around 7:05 AM she had overheard CNA 4 communicating with Resident B "loudly and with swear words." Registered Nurse (RN) 7's statement indicated		requirements and took immediate action to ensure the safety of the resident, and investigation into allegations of verbal abuse. While the facility and the opinion of surveyor on the facility conclusion differ, the facility had already implemented corrective actions and ensured the safety of the resident. The resident remains at the facility, feels safe, and has ongoing psych-social support of social service team. The employee involved in the matter had already been separated from employment. Facility completed interviews of other residents that may have had potential to be affected and no other residents were affected. Measures put into place to ensure systemic changes included re-educate employees regarding facility policies with respect to abuse. Employees will receive ongoing education and be able to demonstrate understanding of policy elements. Residents are made aware of abuse procedures upon admission and will receive ongoing education regarding abuse and abuse reporting. - DON/Designee, will audit residents for possible abuse by interviewing 10 random selected residents. For those who cannot be interviewed, Residents' will be observed for any reported or observed signs of abuse. QA will be responsible for oversight. A	

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	around 6:45 AM, CNA 4 had walked up to her medication cart. CNA 4 indicated "Resident B does this everyday and gets on my nerves" to RN 7. RN 7 indicated Resident B just needed to use the bathroom, CNA 4 indicated okay and walked away. CNA 6's statement indicated she had heard CNA 4 talk loudly in Resident B's room at around 6:45 AM. Resident B's statement, dated 5/18/23 at 8:30 AM, indicated "CNA 4 upset her all the time and Resident B doesn't say anything. CNA 4 always had remarks for her." Resident B indicated every time she returned from a meal she had to utilize the bathroom and CNA 4 told her to put her light on as she was tired of helping her. Resident B indicated on 5/18/23 she had went into the hallway because she needed assistance to the bathroom. CNA 4 indicated she wouldn't help Resident B to the bathroom. Resident B had told CNA 4 if she did not help her then there would be a mess and then CNA 4 assisted her. Resident B indicated she overheard CNA 4 tell someone else that "she was tired of messing with me (Resident B) and had done it for a long time." Resident B indicated she had not wanted to say anything so there was not any trouble, but RT 3 had reported the conversation. Resident B also indicated CNA 4 "always had nasty comments and was short fused when Resident B had to go to the bathroom." CNA 4's statement indicated Resident B had went out into the hallway and insisted to be assisted in utilizing the bathroom. CNA 4 indicated she had told Resident B she had been with another resident and would be with her next. CNA 4 indicated Resident B was upset and told other		Quality Assurance Audit has been created to ensure our corrective measures stay corrected. The audit will be completed weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for 2 months, for at least 6 months of monitoring. All findings will be reported by the Administrator and reviewed at the QA Meeting Monthly for 3 months and then quarterly thereafter. DON/Designee will audit by interviewing 10 staff, with selection from all three shifts, to ensure staff can demonstrate verbally actions to take should they suspect abuse. QA will be responsible for oversight. A Quality Assurance Audit has been created to ensure our corrective measures stay corrected. The audit will be completed weekly for 8 weeks, then bi-weekly for 8 weeks, then monthly for 2 months, for at least 6 months of monitoring. All findings will be reported by the Administrator and reviewed at the QA Meeting Monthly for 3 months and then quarterly thereafter.We respectfully request paper compliance.	

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	staff CNA 4 would not help her. CNA 4 indicated she then assisted Resident B and tried to explain "this goes on everyday and the resident denied." CNA 4 indicated RT 3 then entered the room and asked CNA 4 to leave the room. A list of interviewable residents was provided by the Administrator on 5/30/23 at 10:46 AM. The list indicated Resident B was interviewable. A record review for Resident B was completed on 5/30/23 at 11:18 AM. Diagnoses included: overactive bladder, depression and anxiety. A nursing note, dated 5/18/23 at 7:05 AM indicated RT 3 had overheard the resident ask CNA 4 for assistance with the bathroom and the CNA had yelled at her stating she was just in there 15 minutes ago and she couldn't keep coming in there every 5 minutes. The RT stood outside the door and overheard CNA 4 yell at resident for b****ing and complaining all the time. The CNA told the resident multiple times all she does is b****. The resident told the CNA she bitches and complains all the time too. RT 3 entered the room and asked CNA 4 to leave the room. Resident B was visibly upset and crying. In an interview on 5/30/23 at 10:07 AM, CNA 8 indicated abuse can be emotional, which included yelling and screaming. CNA 8 indicated no one should make negative statements/comments about residents, in front of them or around them. A policy, dated March 2020, titled "Abuse Reporting - Staff Treatment of Residents," was provided by the Administrator on 5/30/23 at 10:46 AM. The report indicated..."verbal abuse: means any use of oral, written or gestured language that included disparging and derogatory terms to			

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	residents or their families, or within their hearing distance, to describe regardless of their age the resident's ability to comprehend or disability." This Federal citation is related to Complaint IN00408892. 3.1-27(b)			